MERCY HIGH SCHOOL
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM
(Adapted from Maryland State Department of Education Form)

This order is valid only for school year 2019-2020.

This form must be completed in full in order for the school to administer any required medication. A new form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication during the school year.

1. Prescription medication must be in a container labeled by the pharmacist or prescriber.
2. Non-prescription medication must be in the original container with the label intact.
3. An adult must bring the medication to the school.
4. If a question arises about the student's medication, the school's Case Manager/Delegating Nurse will call the prescriber, as allowed by HIPPA.

Prescriber's Authorization

Name of Student: _____Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: ___ None expected ___ Specify: _____

Medication shall be administered from: _____ to _____
Month/Day/Year Month/Day/Year

Prescriber's Name/Title: _____ (This space for prescriber's address stamp)
(Type or print.)
Telephone:_____ FAX: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp ONLY)

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medication treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the Case Manager/Delegating Nurse to communicate with the health care provider as allowed by HIPPA.

Parent/Guardian Signature: _____Date:_____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of **emergency** medication may be authorized by the prescriber and must be approved by the school Case Manager/Delegating Nurse according to the State medication policy.

Prescriber's authorization: Signature: _____ Date: _____

School Delegating Nurse approval: Signature: _____ Date: _____

ORDER REVIEWED BY MHS DELEGATING NURSE: _____ Date: _____

Revised 9/6/2017