MERCY HIGH SCHOOL — BALTIMORE —

**A NEW FORM IS NEEDED EACH SCHOOL YEAR**

## OVER-THE-COUNTER PERMISSION/AUTHORIZATION FORM

The Over-the-Counter Medication Permission/Authorization Form is to be completed, signed and returned to Mercy High School by the first day of orientation. Part I is to be completed (check yes or no) and signed by a parent/guardian. Part II is to be completed and signed by your daughter's physician. No medications of any type will be given to your daughter until this form, Part I and Part II, is completed and on file in the Health Office. It is school policy and state law that no student may carry or take any medications unless under the supervision of the school nurse/school administrators.

### PART I: Parent Consent for Administration of Over-the-Counter Medication

Student's Name _____ Year of Graduation _____

Known Allergies _____

Medications Taken Regularly _____

Check the over-the-counter medications listed below that you wish to be available to your daughter in school.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1. | Acetaminophen (generic Tylenol) | Yes ____ | No ____ | | 5. | Neosporin bacitracin ointment | Yes ____ | No ____ | |
| 2. | Ibuprofen (generic Advil) | Yes ____ | No ____ | | 6. | Hydrocortisone cream .5-1% | Yes ____ | No ____ | |
| 3. | Antacid (generic Tums) | Yes ____ | No ____ | | 7. | Benadryl | Yes ____ | No ____ | |
| 4. | Cough Drops | Yes ____ | No ____ | | | | | | |

I give permission for my daughter to receive the above medications that I have checked during school hours to be administered by the school nurse.

_____ _____

Parent/Guardian Please PRINT Clearly Parent/Guardian Signature

---

### Part II: Physician Authorization Form for Over-the-Counter Medications

Student's Name _____

| | | | |
|---|---|---|---|
| 1. | Acetaminophen (325 mg) 1-2 tabs po q4hr pm<br>(for headache, fever, mild muscle discomfort, menstrual cramps) | Yes _____ | No _____ |
| 2. | Ibuprofen (200 mg) 1-2 tabs q4-6 hr prn<br>(for headache, mild to moderate muscle discomfort, menstrual cramps) | Yes _____ | No _____ |
| 3. | Antacid (Tums) 1-2 tabs po<br>(for mild to moderate gastric hyperacidity) | Yes _____ | No _____ |
| 4. | Cough drops 1-2 po prn<br>(for mild throat irritation or cough) | Yes _____ | No _____ |
| 5. | Bacitracin/Neosporin ointment topical<br>(for minor cuts, skin abrasions) | Yes _____ | No _____ |
| 6. | Hydrocortisone cream 0.5-1% topical<br>(for insect bites, mild rashes) | Yes _____ | No _____ |
| 7. | Benadryl 25 mg to 50 mg po q4-6 hrs prn<br>(for allergic reactions) | Yes _____ | No _____ |

_____ _____

Physician's Signature Date

*Stamp physician name, address
and phone number here.

Revised 5/2021

**Mercy High School**
**School Medication Administration Authorization Form**

This order is valid only for school year (current) _____ including the summer session.

This form must be completed fully in order for schools to administer the required medication. A new medication administration 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.

* Prescription medication must be in a container labeled by the pharmacist or prescriber.
* Non-prescription medication must be in the original container with the label intact.
* An adult must bring the medication to the school
* The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

## 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: _____
(Type or print)

Telephone: _____ FAX: _____

Address: _____

_____

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

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): _____ for the above medication on (Date): _____

## 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 medical 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 school nurse to communicate with the health care provider as allowed by HIPAA.

**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 nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: _____ _____
Signature Date

School RN approval for self carry/self administration of emergency medication: _____ _____
Signature Date

Order reviewed by the school RN: _____ _____
Signature Date

Revised 5/2021