ANNE ARUNDEL COUNTY
SCHOOL HEALTH SERVICES PROGRAM

PARENT'S REQUEST TO ADMINISTER MEDICATION AT SCHOOL

FOR COMPLETION BY PARENT/GUARDIAN

Name of Student:_____ D.O.B:____/____/____
(LAST) (FIRST) (MI)

Name of School:_____ Grade:_____ School Year:_____

In order for my child to receive medication in school, I agree to the following:

- All prescription and non-prescription medication will have a physician's signed order **fully** completed for each school year.
- The prescription medication will be in a container labeled by the pharmacist or physician with:
- *Name of child.* *Name of the medication.* *Dosage, route and time of administration.*
- *Name of physician.* *Prescription date and expiration date.* *Conditions for proper storage.*
- The non-prescription medication will be in the original sealed container with the label intact. Student's name will be put on the container in a position that does not obscure the label.
- The medication will be brought to school by an adult.
- The physician will be called if a question arises about my child's medication.
- The first dose of this medication (except for epinephrine auto-injector) has been given without problems.

Having read the above conditions, I request Anne Arundel County School Health Services personnel administer the medication as prescribed by the physician below. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school.

Signature of Parent/Guardian:_____ Date:_____

Relationship to student _____
Phone Number: (H)_____ (W)_____ Other_____
Address: _____

PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL
ONE MEDICATION PER FORM

Diagnosis: _____

Name of Medication: _____

Dosage: _____(mg, ml, ml/tsp, # of puffs)

Route:_____ Time of Administration at School: _____ ☐ Lunchtime

If PRN, for what symptoms? _____How Often?_____

Please list any specific precautions personnel should be aware of or any unusual effects that might be observed.

_____

Student medication allergies: ☐ None Known _____

Services from ☐ the beginning to the end of school year **OR**
Services should begin (Date) _____ and terminate (Date)_____ .

FOR INHALER, EPINEPHRINE AUTO-INJECTOR, AND INSULIN ONLY:

_____ It has been determined that this student is able to self-administer and carry inhalant medication or epinephrine auto-injector and has been trained in its use, including knowing when the medication is to be used.

_____ It has been determined that this student is able to self-administer insulin.

_____ This student should not self-administer inhalant medication, insulin, or epinephrine auto-injector.

Physician's Signature: _____ Date: _____
Original signature/NO stamps

Physician's Name (Printed): _____

Address: _____

Telephone Number:_____

☐ Order and MAR Reviewed _____R.N. Date_____