BALTIMORE CITY HEALTH DEPARTMENT **BALTIMORE CITY PUBLIC SCHOOLS**

SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

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

This form must be entirely completed in order for school health staff 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 a pharmacist or healthcare provider.
- Non-prescription medication must be in the original unopened/sealed container with the label intact.
- An adult must bring in the medication to the school.
- The school nurse (RN) will call the healthcare provider, as allowed by HIPAA, if a question arises about the student and/or the student's medication.
- **Expired and discontinued medication not picked up by the last day of school will be destroyed.**

HEALTHCARE PROVIDER'S AUTHORIZATION

Student Name: _____Birth Date: _____Grade: _____ School #: _____

Condition for which medication is being administered: _____

Medication Name: _____ Strength: _____

Dose: _____ Route: _____ ☐ Time(s) In School: _____

☐ PRN & Frequency: _____ for what symptoms? _____

Relevant side effects: ☐ None expected ☐ Specify: _____

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

(Healthcare Provider's Office Stamp)

Healthcare Provider's Name/Title: _____
(Type or print)

Office #: _____FAX #:_____

Address: _____

_____

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

Discontinue Medication (HCP Signature): _____ Date: _____

PARENT/GUARDIAN AUTHORIZATION

I understand that designated school health staff will administer the medication as prescribed by the above healthcare provider. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I acknowledge that the school nurse can communicate with the healthcare provider as allowed by HIPAA.

Parent / Guardian Signature: _____Date: _____

Home Phone #: _____Cell #: _____Work #: _____

FOR ALTERED SCHOOL SCHEDULES, THE FOLLOWING MEDICATION GUIDELINES WILL APPLY UNLESS OTHERWISE INDICATED IN WRITING:

- One hour delayed opening: doses will be given as usual.
- Two hour delayed opening: medications scheduled to be given before 10 a.m. will not be given in school; other doses will be given according to the prescribed schedule.
- Three hour early dismissal: medications scheduled to be given at lunchtime or later will not be given.

SELF CARRY/ SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of **emergency** medication may be authorized by the healthcare provider and must be approved by the school nurse according to the School Medication Administration Policy.

Healthcare Provider's authorization for self-carry/self-administration of emergency medication: _____
Signature Date

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

Date received in health suite: _____by: _____

Order reviewed by School Nurse (Print): _____Signature:_____Date: _____