Medication rec'd _____ Daily _____
Exp. Date _____ PRN _____

PHYSICIANS MEDICATION ORDER FORM

This order is valid only for school year (current) _____. DATE RECEIVED: _____PRN/STANDING
School: Carroll Christian Schools, 550 Baltimore Blvd., Westminster, MD 21157 410-876-3838
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 OR specify:_____

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

ALLERGIES:_____

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 MEDICATION AUTHORIZATION APPROVAL OF INHALANT MEDICATION OR EPI-PEN ONLY

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. It has been determined that this student is able to self-administer inhalant medication or Epi-pen and has been trained in its use including knowing when the medication is to be used.

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