Known Drug Allergies:

Physician Medication Order Form [PMOF]

Medication Administration Release and Authorization Form

Parental Waiver of Liability - Physician Request to Administer Medication During School Hours

NOTE: Use a separate form for each medication order. The Calverton School, without the written authorization of the parent and physician, cannot administer medication, prescribed or over the counter. This form must be kept current. The parent is responsible for providing all information needed for the proper administration of medication. A confirmation of current medications, which must be administered during school hours, must be made or renewed at the beginning of each school year. *Whenever there is a change in medication, the parents must have a new form completed by the physician.*

Student Name: _____ Grade: _____ Date of Birth: _____

To be completed by physician:

Medical Diagnosis of above named student: _____

The following medication is given during school hours: Medication Name _____

Route of Administration_____ Time/Frequency of Administration_____

Dosage _____ If PRN, for what symptoms _____

FOR INHALER AND EPI-PEN MEDICATION ONLY (for students in Grades 6 to 12):
_____ **is able to self-administer** and carry inhaler medication or Epi-pen.
_____ **is trained in use** of inhaler and/or Epi-pen and knows when the medication is to be used.
_____ **should not self-administer** inhalant medication or Epi-pen.

I hereby consent and authorize the school Nurse and medication assistants of The Calverton School to administer the aforementioned medication to _____.

Physician's Name (Print Clearly) _____

Physician's Signature _____ Date_____ Telephone Number _____

SCHOOL NURSE/MED TECH AND/OR HOUSE PARENT OF RESIDENTIAL HOMES MAY ADMINISTER THE FOLLOWING OVER-THE-COUNTER MEDICATIONS:

Put a check mark beside the following medications that may be administered on an as-needed basis. All medications must be given directly to the Nurse in their original unopened package. All medications are given per package dosage instructions. All dosages given per package instructions, unless otherwise noted.

___ Cough Drops ___Ibuprofen – dose _____ ___Tylenol – dose ____ ___Claritin-dose ____ ____Tums ____Orajel
___ Topical Neosporin ___Topical Hydrocortisone ___Benadryl – dose ___ Other _____

The parent must bring this completed form to The Calverton School, ***along with a continuing supply of medication in the original pharmacy container. A student must not transport medications. By signing below, the parent understands the possible consequences in the administration of the aforementioned medication. In consideration of administering said medication, the parent hereby releases, waives, discharges and hold harmless The Calverton School, its officers, director, and employees from any claims, demands, or suits for damages from any injury or complication which may result from the administration of the aforementioned medication.***

Parent/Guardian Signature _____ ***Date*** _____

Relationship to Student_____ ***Daytime Phone Number*** _____

Person to contact in case of emergency if parent/guardian cannot be reached: _____

_____

Please return this form to the Nurse:

The Calverton School, 300 Calverton School Road, Huntingtown, Maryland 20639 FAX: 410.535.6169