MARYLAND STATE
SCHOOLMEDICATION ADMINISTRATION AUTHORIZATION FORM

Thisorder is valid only for school year (current) _____ including the summer session.
School: _____
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 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 _____ Date: _____
Signature: 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

2023