

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 has allergies to the following medications: \_\_\_\_\_

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 \_\_\_\_\_