CARROLL COUNTY PUBLIC SCHOOLS MEDICATION FORM

Name: _______________________________ D.O.B.:______________ Allergies: _________________________________Grade/Teacher: _______________Bus #____________

Medication:___________________________ Route: _____________________ Strength: _____________ Dosage: _____________ Time: _________**Expiration Date:**_________

From: ___________________ To: _____________________ Reason: ___________________________________ Side Effects: ____

If medication administration is necessary during school hours, this form must be completed before any representative of the school can administer prescription or non-prescription medications to your child. **Special Notes:**

1. **Prescription Medications must be in a container marked specifically for student, labeled by pharmacist or prescriber. Over the counter medications must be in original container with manufacturers label intact.**
2. **All homeopathic/herbal prescription AND non-prescription medicines require a parent AND physician/dentist or nurse practitioner signature. (Physician's Assistant signature NOT acceptable) *EXCLUSION: Ibuprofen and Acetaminophen in age appropriate doses only.**
3. **Medications are not to be transported by students. This is in violation of our Drug-Alcohol policy. Leftover medication will be returned to parent, guardian or designated adult. Unused, unclaimed, or expired medicines will be destroyed at the end of the school year.**
4. **Medication orders are only valid for the current school year including ESY.**

*** (Maryland law allows prescription medication to be used only for 1 year beyond date of issue or expiration date indicated on the medication – whichever comes first.)**

I authorize and request representatives of Carroll County Public Schools to administer the medication listed above, in doing so, relieve them of ill effects resulting from the administration of medication to my child. I also give them permission to contact the physician for any questions regarding the administration of this medication.

Parent/Guardian Signature:____ **Physician/Prescriber Signature:**___________________________________

Physician/Prescriber Phone #______________________________

Inhaler Release: (It is the student's responsibility to report usage to the school nurse)
This section must be completed in addition to above for those students who request permission to carry their own inhaler.
We acknowledge that the student named above has been instructed as to the proper use, understands the purpose and the appropriate method as well as the frequency of use of their inhaler. We request that the student may be able to carry their inhaler on their person or secured in their locker.

Parent/Guardian Signature:____________________________________ **Physician/Prescriber Signature:**_____________________________

Codes (chart reason)
A – Absent
C – School Closed
E – Early Dismissal
F – Field Trip
H – Holiday
L – Late Opening
N – None Available
O – No Show
W – Dose Withheld

Initial	**Name**	**Initial**	**Name**
_____	______________________________	_____	______________________________
_____	______________________________	_____	______________________________
_____	______________________________	_____	______________________________

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
August																															
September																															
October																															
November																															
December																															
January																															
February																															
March																															
April																															
May																															
June																															
July																															

MEDICATION COUNT

DATE	MEDICATION	STRENGTH	REC'D	COUNT	TOTAL	INT

NURSING NOTES

DATE	COMMENTS

Initial: ________ Name: ________________________ Initial: ________ Name: ________________________

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