

Over The Counter Medication Form

**Maryland Department of Human Resources
Child Care Administration
Medication Order Form**

Regulations permit child care providers to give prescription and non-prescription medication to children in care under certain conditions. Prior written permission from the child's parent is a requirement. If possible, arrange the time of dosage so the child receives the medication at home. Fill out a separate form for each prescription or non-prescription drug.

Non-Prescription Medication

A child may receive only one dose during care, except acetaminophen (Tylenol) and topical medication. A licensed health practitioner must approve the medication and dosage for the child to receive more than one dose.

Name of Child: _____

This medication is being given for the following condition(s): _____

Medication	Dosage	Hour Given	Dates To Administer	
			Start	Stop

Note any side effects of this medication _____

I/We authorize St. Philip Neri School
Health Room Aides to administer the above named medication to my/our child.

Signature of Parent _____ Date _____

MARYLAND STATE
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order 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 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 Specify: _____

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

Prescriber's Name/Title: _____

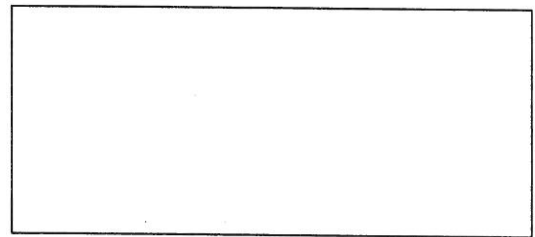
(Type or print)

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 Signature: _____ Date: _____

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