The Park School of Baltimore

PHYSICIAN'S MEDICATION AUTHORIZATION FORM

A **Physician's Medication Authorization Form** must be completed at the beginning of each school year for all medications.

- This form must be completed and signed by the parent and the child's medical provider in order for us to administer the required medication. This includes both prescription and over-the-counter (OTC) medications.
- All prescription medication must be in a container with the pharmacist's label attached.
- Non-prescription medication must be in the original container with the manufacturer's original label intact.
- The medication is required to be brought to school by a parent/guardian or responsible adult.
- It is recommended that the first full day's (24 hours) dose of any new medication be given at home.

HEALTH CARE PROVIDER'S INSTRUCTIONS FOR GIVING MEDICATION

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: _____

Prescriber's Signature: _____Date:_____

Telephone: _____FAX: _____

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 #: _____

AUTHORIZATION FOR STUDENT TO CARRY EPI-PEN AND/OR INHALER

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 (Signature and Date): _____

Parent/Guardian (Signature and Date): _____

To Be Completed by School Nurse: Medication expires: _____

Contact School Nurse at (410) 339-4149.