

**FREDERICK COUNTY PUBLIC SCHOOLS/FREDERICK COUNTY HEALTH DEPARTMENT  
MEDICATION AUTHORIZATION FORM**

This order is valid only for the current school year \_\_\_\_\_ (Including Summer Session)

**OR**

Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ to Stop Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*This medication form must be completed fully in order for staff to administer 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 provider.
- Over-the-counter medication must be in the **original unopened container** with the label intact.
- Students are prohibited from transporting medications.
- The provider will be called if a question arises about the student and their medication.
- Thoroughly review reverse side of form before completion.

**HEALTH CARE PROVIDER AUTHORIZATION**

Name of Student:		Date of Birth:
Allergies:		Grade:
Condition for which medication is being administered:		
Medication Name:	Dose:	Route:
Time of Administration:	If PRN, frequency:	
Additional Instructions:		
Relevant side effects: <input type="checkbox"/> None expected <input type="checkbox"/> Specify:		
Specific Instructions for Inhalers: Symptoms for Inhaler administration: Coughing   Audible wheezing   Complaint of tightness in chest Complaint of shortness of breath   Other _____		
Health Care Provider's authorization for student to: Self-carry: Yes No    Self-administration: Yes No		
Health Care Provider's name/title: (type or print)		
Telephone:	Fax:	Use for Health Care Provider's Address Stamp
Address:		
Health Care Provider's Signature:	Date:	

**PARENT/GUARDIAN AUTHORIZATION**

I request designated staff to administer the medication as prescribed by the health care provider above. I certify that I have legal authority to consent to the administration of medication at school. I understand that at the end of the school year that the medication must be picked up by an adult or it will be destroyed.

Parent/Guardian Signature:	Date:
Parent/Guardian Phone:	Work Phone:

**REGISTERED NURSE AUTHORIZATION**

School registered nurse approval for student to: Self-carry: Yes No    Self-administration: Yes No

Signature:	Date:
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## IMPORTANT INFORMATION FOR PARENTS/GUARDIANS AND PHYSICIANS

1. Please give your child needed medication at home if at all possible.
2. It is recommended that the first full day's (24 hours) dose of any new medication be given at home. If unsure, follow the recommendation of the health care prescriber about attending school during the first 24 hours.
3. If it is **ABSOLUTELY NECESSARY** for the student to take prescription, over-the counter or alternative medication at school or on field trips, this *School Medication Administration* form must be completed for each medication and submitted to the health services staff/principal's designee prior to medication being given at school.
4. Medications will be administered by the health services staff. In their absence, the principal will designate a school system employee to assume this responsibility.
5. All medications must be labeled with the name of the medication, name of the student, name of the health care prescriber, date, and directions (e.g., specific time and dose) for administration. Prescription medication must be labeled by a registered pharmacist unless ordered directly from a pharmaceutical company.
6. When a student requires medication by an inhaler or by a mechanical device:
  - a. The health care prescriber must indicate on the school medication administration form if the student may carry the device with him or her and whether the student can use the device with or without supervision.
  - b. The order must be received, reviewed, and approved by a Frederick County Health Department registered nurse.
  - c. The parent/guardian or child may demonstrate the use of the mechanical device to the staff person who will monitor or administer the medication by mechanical device and provide information regarding potential adverse effects as needed.

**SAMPLE LETTER**

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Date

Dear Parent/Guardian:

In an effort to keep our children and youth safe before, during, and after school, we require that an adult bring ALL needed medication to school rather than sending it with your child. Although your child may be responsible, non-predictable events may occur which allow another child to have access to the medication, possibly putting him/her at risk.

Please help us maintain an environment safe for all our students by keeping it free of all medications. Please feel free to speak with the school principal or school's registered nurse if you have questions.

Thank you for your cooperation.

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Principal

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Frederick County Health Department  
Registered Nurse



FREDERICK COUNTY SCHOOL HEALTH PROGRAM  
Incident Report – Medication Administration

SCHOOL: \_\_\_\_\_

STUDENT: \_\_\_\_\_

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ DOB: \_\_\_\_\_  
(month/day/year)

DATE AND TIME OF ERROR: \_\_\_\_\_

NAME OF PERSON ADMINISTERING MEDICATION: \_\_\_\_\_

NAME OF MEDICATION AND DOSAGE PRESCRIBED: \_\_\_\_\_

DESCRIBE CIRCUMSTANCES LEADING TO ERROR: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

PERSONS NOTIFIED OF ERROR AND COPY OF REPORT:

SUPERVISOR \_\_\_\_\_

PRINCIPAL \_\_\_\_\_

PARENT \_\_\_\_\_

PHYSICIAN (if applicable) \_\_\_\_\_

OTHER \_\_\_\_\_

SIGNATURE OF PERSON COMPLETING INCIDENT REPORT: \_\_\_\_\_

FOLLOW-UP INFORMATION IF APPLICABLE:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

cc: FCHD School Nurse/School Health Manager  
FCPS Health Specialist  
Principal