Prince George's County Public Schools
Office of School Health

Prescriber's Medication Order Form

(**ONE** medication per form)

This order is valid ONLY for the school year (current) _____ including the ESY/summer session.

PART 1: PARENT/LEGAL GUARDIAN TO COMPLETE		
Student's Name:		**Birthdate:**
School:		Grade:
Parent/Guardian Name (print):		
Home phone #:	**Cell phone #:**	**Work phone #:**
Known Allergies: □ None	□ Specify:	

- I hereby authorize the medication described below to be administered as directed by my child's health care prescriber.
- I understand that the prescriber will be called if a question arises about my child's medication as allowed by HIPAA.
- I understand that **ALL** medications must be labeled with the name of the medication, name of the student, name of the prescriber, date, and directions for administration and prescription medication(s) must be labeled by a registered pharmacist.
- I understand that I must supply the school with the equipment/supplies needed to administer the medication.
- I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded.
- I understand **911 will be called immediately** if a medical condition warrants it.

Parent/Guardian Signature:	**Date:**

PART 2: LICENSED PRESCRIBER TO COMPLETE	
Medication Name:	**Dose:**
Reason for Medication:	
Medication Form: □ Capsule/Tablet □ Injection □ Liquid □ Other:	**Time to be given:**
Route: □ By mouth □ By inhalation □ By injection □ Rectal □ Topical □ Other:	
PRN frequency: □ every 2 hours □ every 4 hours □ every 6 hours □ Other:	If PRN, for what symptoms:
Side Effects:	
Special Instructions:	
Medication start date (**month/day/year**):	**Medication end date** (**month/day/year**):
Prescriber's Name/Title (printed):	
Prescriber's office phone #:	**Prescriber's office fax #:**
Prescriber's office address:	
Prescriber's Signature: (**Original Signature or signature stamp only**)	Date:

FOR SELF-ADMINISTRATION/SELF-CARRY ONLY OF ASTHMA/EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of **emergency medication** MUST be authorized by the prescriber and supported by the school nurse's assessment according to Medication Administration policy #5163.

Has this student been instructed by you or your staff and demonstrated competence in self administration of medication to the degree that he/she may self- administer his/her medication at school, provided that the school nurse has determined it is safe and appropriate for this student in his/her particular school setting?

□ Yes □ No

Prescriber's Signature: **PGCPS RN/LPN Signature:**

Order reviewed by RN/LPN:	**Date:**

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Medication Administration Record

Student Name: DOB: Allergies:

Medication, Dose, Route, Time/Frequency	Mo / Yr	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
	Aug																															
	Sep																															
	Oct																															
	Nov																															
	Dec																															
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	Feb																															
	Mar																															
	Apr																															
	May																															
	Jun																															
	Jul																															

* Disposition Code: **A** = Absent **R** = Refused **NMA** = No Medication Available **D** = Destroyed **X** = School Closed

Signature(s) of Medication Administrators	Position	Initials

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