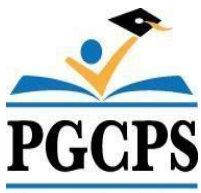


Prince George's County Public Schools
Office of School Health
Prescriber's Medication Order Form
(ONE medication per form)

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: <input type="checkbox"/> None | | <input type="checkbox"/> Specify: |
| <ul style="list-style-type: none">• 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 <u>and</u> 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: <input type="checkbox"/> Capsule/Tablet <input type="checkbox"/> Injection <input type="checkbox"/> Liquid <input type="checkbox"/> Other: | | Time to be given: |
| Route: <input type="checkbox"/> By mouth <input type="checkbox"/> By inhalation <input type="checkbox"/> By injection <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Other: | | |
| PRN frequency: <input type="checkbox"/> every 2 hours <input type="checkbox"/> every 4 hours <input type="checkbox"/> every 6 hours <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Prescriber's Signature: | | PGCPS RN/LPN Signature: |
| Order reviewed by RN/LPN: | | Date: |



Prince George's County Public Schools
Office of School Health
Prescriber's Medication Order Form
(ONE medication per form)

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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Jan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 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 |
|---|----------|----------|
| | | |
| | | |
| | | |

| Signature(s) of Medication Administrators | Position | Initials |
|---|----------|----------|
| | | |
| | | |
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