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:**		