BALTIMORE COUNTY PUBLIC SCHOOLS
Towson, Maryland 21204

BALTIMORE COUNTY DEPARTMENT OF HEALTH
Baltimore, Maryland 21212

PARENT'S REQUEST TO ADMINISTER MEDICATION IN SCHOOL

Dear Parent/Legal Guardian:

To request medication administration at school, please note:

- This form must be completed and signed by you and your child's health care provider.
- A new form is needed for all changes in medication, dose, or time.
- Use of the medication or dietary supplement must be permitted by both federal and Maryland law.
- The medication should be brought to school by a parent/guardian or responsible adult.
- Prescription medications must be in a container that is labeled by the pharmacy with the student's name, prescriber's name, name of medication, dosage, route, conditions for storage, prescription date, and expiration date.
- Over-the-counter medications and dietary supplements must be in a container that is commercially labeled and includes the name of the drug or supplement, its strength, conditions for storage, and expiration date.
- Unless otherwise specified, medication order is valid for the entire school year.
- **Expired and discontinued medication not picked up by the last day of school will be destroyed.**

HEALTH CARE PROVIDER'S INSTRUCTIONS FOR GIVING MEDICTION IN SCHOOL

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: _____

Special/Emergency Instructions: _____

Prescriber's Name/Title: _____ Telephone: _____

Address: _____ Fax: _____

Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp ONLY)

AUTHORIZATION FOR STUDENT TO CARRY EPINEPHRINE AUTO-INJECTOR AND/OR INHALER

Prescriber Authorization: _____
Signature Date

Parent/Guardian Authorization: _____
Signature Date

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.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone # _____

For Altered School Schedules, the Following Medication Guidelines Will Apply Unless You Indicate Otherwise in Writing:

- One hour late opening: doses will be given as usual, with minor modifications in timing, if needed.
- Two hour late opening: medications scheduled to be given before 10 a.m. will not be given in school; other doses will be given according to the prescribed schedule.
- Three hour early dismissal: medications scheduled to be given at lunchtime or later will not be given.

TO BE COMPLETED BY SCHOOL

Date form received at school: _____ Received by: _____