MARYLAND STATE
BALTIMORE CITY HEALTH DEPARTMENT
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for the (current) school year ____________________ Including the summer session.

School: ____

This form must be completed fully in order for schools to administer the 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 a pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- An adult must bring in the medication to the school.
- The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication

PRESCRIBER'S AUTHORIZATION

Name of Student: ______________________________ Date of Birth: ____________________ Grade: ________

Condition for which medication is being administered: ______________________________________

Medication Name: ______________________________________ Strength: ____________________

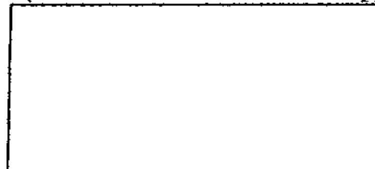
Dose ____________________ Route ______________________ Time(s) **In School** ____________________

PRN _____ frequency: ____________ for what symptoms? ______________________________________

Relevant side effects: ☐ None expected ☐ Specify: ______________________________________

Medication shall be administered from: ____________________ to ____________________
Month/Day/Year Month/Day/Year

(Use for Prescriber's Address Stamp)



Prescriber's Name/title: ______________________________
(Type or print)
Office #: ____________________ FAX ____________________
Address: ______________________________________
____

Prescriber's Signature: ______________________________
(Original signature or signature stamp ONLY)
A verbal order was taken by the school RN Name): ____________________ for the above medication on (Date): _______

Discontinue Medication (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 as allowed by HIPAA.

Parent / Guardian Signature: ______________________________________ **Date:** ____________

Home Phone #: ____________________ **Cell #:** ____________________ **Work #:** ____________________

SELF CARRY/ SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/ self-administration of **emergency** medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self-carry/self administration of emergency medication: ______________________________
Signature Date

School RN approval for self-carry/self administration of emergency medication: ______________________________
Signature Date

Date received in health suite: ____________________ by: ______________________________
Order reviewed by school RN: ______________________________ Date: ____________________

SH 7 rev. 10/07

1150-14-106

The School Medication Administration Policy applies to prescription and over-the-counter medications:

1. **All medication order forms must be completed by a medical provider and signed by parent/guardian each school year. Forms may be obtained from the school nurse/ health aide or from our web site at** www.baltimorehealth.org.

2. **Medication cannot and will not be given unless completed forms for each medication are received. Medication cannot be given without the order form.**

3. **The first dose of any new medication cannot be given in school. (Exceptions include: EpiPen, Metered Dose Inhaler, Glucagon)**

4. **The medication must be brought to the Health Suite by a parent/guardian or responsible adult.**

5. **The school health staff will <u>not</u> administer any medication without written orders from a health care provider. All medication must be pharmacy labeled.**

6. **The prescription medication must be labeled by the pharmacy with the student's name, prescriber's name, medication name, dose, route, time, and expiration date. All inhalers <u>must</u> be in a pharmacy labeled box when brought to the Health Suite.** ***All labels must match health care providers orders.***

7. **The over-the-counter medication must be in the original unopened box or container.** ***Does not have to be pharmacy labeled.***

8. **A separate form must be completed for each medication prescribed. All medication, time, or dose changes require a new medication form.**

9. **Discontinued medication will be held for one week after request for pick up. All remaining medication beyond that date will be destroyed.**

10. **Any student found with medication in school without orders from a medical provider will have their medicine taken and held in the health suite. Parent/guardian will be notified and requested to pick up medication.** ***Medication remaining after one week will be destroyed.***

11. **Medication will be destroyed if not picked up by the last day of school or when it expires.**

Baltimore City Health Department **SCHOOL HEALTH PROGRAM**	**6. NURSING SERVICES** **c. Asthma-Student Health Questionnaire**

To better serve a student's health care needs, the school health program requests this questionnaire be completed for all students identified with asthma. Please answer the following questions:

Date__________________

Name_________________________________ **Date of Birth**__________________

School _________________________________ **Grade/Class** __________________

Parent/Guardian __________________________ **Home Phone** __________________

Address________________________________ **Work Phone** __________________

Medical Provider__________________________ **Provider Phone**________________

1. **What are the first signs of asthma attack for your child? Please describe below:**
____
____

2. **Does your child know his first signs and when to seek help?** Yes No

3. **What usually causes an attack, if known?** ____
____

4. **How often does your child have an attack?** _______ wk _______ mo _______ yr

5. **Does your child miss days from school because of this condition?** Yes No

6. **Is your child enrolled in the Chronic Health Impaired Program (CHIP)?** Yes No

7. **What medication(s) is your child currently taking? Please list names, dose and how often taken**____
____

8. **What is your child's current best peak flow, if known?** ______________________________

Additional information/Special instructions you would like to share with the school nurse:

____
____
____

Maryland State Asthma Medication Administration School Authorization Form

ASTHMA ACTION PLAN for ___/___/___ to ___/___/___ (or last day of summer school)

Triggers (list): ______

Student's Name: ______ DOB: ______ PEAK FLOW PERSONAL BEST: ______

Parent/Guardian's Name: ______ Home: ______ Work: ______ Cell: ______

ASTHMA SEVERITY: ☐ Exercise Induced ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE

GREEN ZONE : Controller medications — to be used daily

Symptoms/Indications	Medication	Dose	Route	Frequency
☐ Breathing is good ☐ No cough or wheeze ☐ Can work, exercise, play ☐ Other: ______ ☐ Peak flow greater than ______ (80% personal best)				
☐ **Prior to exercise/sports/ physical education**	(Rescue Medication)			
	If using more than twice per week for exercise, notify the health care provider and parent/guardian.			

YELLOW ZONE: Rescue medications — to be added to Green zone medications for symptoms

Symptoms/Indications	Medication	Dose	Route	Frequency
☐ Cough or cold symptoms ☐ Wheezing ☐ Tight chest or shortness of breath ☐ Cough at night ☐ Other: ______ ☐ Peak flow between ______ and ______ (50%-79% personal best)				
	If symptoms do not improve in ______ minutes, notify the health care provider and parent/guardian. If using more than twice per week, notify the health care provider and parent/guardian.			

RED ZONE: Emergency Medications — Take these medications and call 911

Symptoms/Indications	Medication	Dose	Route	Frequency
☐ Medication is not helping within 15-20 mins ☐ Breathing is hard and fast ☐ Nasal flaring or intercostal retractions ☐ Lips or fingernails blue ☐ Trouble walking or talking ☐ Other: ______ ☐ Peak flow less than ______ (50% personal best)				
	Contact the parent/guardian after calling 911.			

Health Care Provider Authorization

I authorize the administration of the medications as ordered above. Student may self-carry medications: ☐ Yes ☐ No

Health Care Provider Name: ______ Signature: ______ Date: ______

Address: ______ City: ______ Zip: ______ Tel: ______ Fax: ______

Parent/Guardian Authorization

I authorize the administration of the medications as ordered above. I acknowledge that my child ☐ is ☐ is not authorized to self-carry his/her medication(s).

Parent /Guardian Signature: ______ Date: ______

Reviewed by School Nurse: Name: ______ Signature: ______ Date: ______ Authorized to self-carry medications: ☐ Yes ☐ N

12/2011

Baltimore City Health Department
Nursing Care Plan – **Medication Administration**

Name ________________ DOB ________ Pupil # ________________

Annual Goal Student will receive medication as ordered by an authorized prescriber
Service Provider(s) BCHD School Health Staff or designee

The Service Provider is responsible for:	**The Family is responsible for the following:**	**The School is responsible for:**
1. Administering the prescribed medication(s) as ordered by the medical provider. 2. Monitoring the student for adverse side effects, signs of over or under medication, and medication intolerance. 3. Enhancing the health education on medication administration, reason and need for taking medication, side effects, name of medication, visual recognition of medication, etc. 4. Conferring with medical provider and parents as necessary.	1. Providing current medical provider orders for medications to be taken during the school day. 2. Providing an adequate supply of medications. No more than a 30 day supply. 3. Following up on medical referrals. 4. Providing current telephone, pager, cell phone numbers.	1. Providing a central locked storage area for medications. 2. Providing a private area for medication administration.

BCHD Nurse's Signature ________________ Witness Signature ________________

Parent/Guardian Signature ________________ Date ________________

SH 330 (meds) Rev. 03/03