Authorization to Administer Prescribed Medication

Release and Indemnification Agreement

MONTGOMERY COUNTY PUBLIC SCHOOLS
MONTGOMERY COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
Rockville, Maryland 20850

PART I: TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize Montgomery County Public Schools (MCPS) and Montgomery County Department of Health and Human Services (DHHS) personnel to administer prescribed medication as directed by an authorized prescriber (Part II below). I agree to release, indemnify, and hold harmless MCPS and DHHS and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering prescribed medication to this student, provided MCPS and DHHS staff are following the authorized prescriber's order as written in Part II below. I have read the procedures outlined on the back of this form and assume the responsibilities as required.

Student Name: Last ____________________ First ____________________ MI____

MCPS ID#________ Date of Birth ___/___/____ School Name -- Choose One --

Prescription: ❑ Renewal ❑ New If new, the first full day's dosage was given at home on: ___/___/____

List all medication(s) student is taking, including over-the-counter medication(s):

Signature, Parent/Guardian ____________________ Phone ____-____-____ Date ___/___/____

PART II: TO BE COMPLETED BY THE AUTHORIZED PRESCRIBER

DHHS and MCPS discourage the administration of medication to students in school during the school day. Any necessary medication that possibly can be administered before and after school should be so prescribed. Only non-parenteral medications are administered except in specific emergency situations. School personnel will, when it is absolutely necessary, administer medication to students during the school day and while participating in outdoor education programs and overnight field trips, according to the procedures outlined on the back of this form.

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

Name of Medication *(trade name or generic)*: ____________________ Diagnosis: ____________________

Dosage: ____________________ Time(s) to be given at school: ____________________

Ranges not accepted (i.e., 1 to 2 tabs or 2 to 4 puffs)

Route of Administration: ____________________

Medication orders effective ❑ Current school year, ***OR*** ❑ Effective dates ___/___/____ to ___/___/____

Side Effects: ____________________

If PRN, specify when indicated (signs/symptoms) ____________________

Frequency of administration (ranges not accepted, i.e. every 2 to 4 hours) ____________________

Authorized Prescriber's Name (print/type)____________________ Phone ____-____-____ Date ___/___/____

Authorized Prescriber Signature____________________

SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of **emergency** medication such as inhalers and epinephrine auto-injectors must be authorized by the authorized prescriber and be approved by the school nurse according to the Maryland State School Health Services Guidelines.

Authorized prescriber's authorization for self-carry/self-administration of emergency medication

Signature ____________________ Date ___/___/____

School Nurse (RN) approval for self-carry/self-administration of emergency medication

Signature ____________________ Date ___/___/____

PART III: TO BE COMPLETED BY THE SCHOOL COMMUNITY HEALTH NURSE OR PRINCIPAL

Check as appropriate:

❑ Parts I and II above are completed, including signatures. (It is acceptable if all items of information in Part II are written on the authorized prescriber's stationery/prescription form)

❑ Prescription medication is properly labeled by a pharmacist.

❑ Medication label and authorized prescriber order are consistent.

❑ Over-the-counter medication is in an original container with the manufacturer's dosage label and safety seal intact.

___/___/____ Date any unused medication is to be collected by the parent/guardian (within one week after expiration of the authorized prescriber's order).

Signature, School Community Health Nurse (SCHN)/Principal ____________________ Date ___/___/____