ANNE ARUNDEL COUNTY
SCHOOL HEALTH SERVICES PROGRAM

PARENT'S REQUEST TO ADMINISTER MEDICATION AT SCHOOL

FOR COMPLETION BY PARENT/GUARDIAN

Name of Student: _____ D.O.B: ___/___/___
(LAST) (FIRST) (MI)

Name of School: _____ Grade: _____ School Year: _____

In order for my child to receive medication in school, I agree to the following:

- All prescription and non-prescription medication will have a physician's signed order fully completed for each school year.
- The prescription medication will be in a container labeled by the pharmacist or physician with:
- *Name of child.* *Name of the medication.* *Dosage, route and time of administration.*
- *Name of physician.* *Prescription date and expiration date.* *Conditions for proper storage.*
- The non-prescription medication will be in the original sealed container with the label intact. Student's name will be put on the container in a position that does not obscure the label.
- The medication will be brought to school by an adult.
- The physician will be called if a question arises about my child's medication.
- The first dose of this medication (except for epinephrine auto-injector) has been given without problems.

Having read the above conditions, I request Anne Arundel County School Health Services personnel administer the medication as prescribed by the physician below. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school.

Signature of Parent/Guardian: _____ Date: _____

Relationship to student _____

Phone Number: (H) _____ (W) _____ Other _____

Address: _____

PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL
ONE MEDICATION PER FORM

Diagnosis: _____

Name of Medication: Benadryl Liquid

Dosage: _____ (mg, ml, ml/tsp, # of puffs)

Route: Oral Time of Administration at School: PRN ☐ Lunchtime

If PRN, for what symptoms? See FARE Form How Often? q6hrs

Please list any specific precautions personnel should be aware of or any unusual effects that might be observed.
May cause drowsiness

Student medication allergies: ☐ None Known _____

Services from ☐ the beginning to the end of school year OR
Services should begin (Date) _____ and terminate (Date) _____ .

FOR INHALER, EPINEPHRINE AUTO-INJECTOR, AND INSULIN ONLY:

_____ It has been determined that this student is able to self-administer and carry inhalant medication or epinephrine auto-injector and has been trained in its use, including knowing when the medication is to be used.

_____ It has been determined that this student is able to self-administer insulin.

_____ This student should not self-administer inhalant medication, insulin, or epinephrine auto-injector.

Physician's Signature: _____ Date: _____

Original signature/NO stamps
Physician's Name (Printed): James R. Banks, M.D/Timothy Andrews, M.D.

Address: 277 Peninsula Farm Rd, Arnold, MD 21012

Telephone Number: 410-647-2600

☐ Order and MAR Reviewed _____ R.N. Date _____

Revised 8/15