We appreciate your help in avoiding the administration of medication during school hours. Whenever possible, please plan for medication to be given at home or before and after school. A separate form must be completed for each medication to be given.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name (Last, first): | | | | | | Date of Birth: |
| School: | | | Grade | | | Teacher: |
| Allergies: | | | | | | |
| Medication: | | | | | | |
| Dosage: | | Route or Administration: | | | Time of Administration: | |
| If given “when needed”, describe indications and how often it can be repeated: | | | | | | |
| Side effects to be reported to doctor: | | | | | | |
| Student is able to self-administer: Yes:\_\_\_\_\_\_\_ No:\_\_\_\_\_\_\_  *This is ONLY applicable for Emergency medications and/or grades 9-12 non-prescription medications.* | | | | | | |
| Student is authorized to carry emergency medication (EpiPen/inhalers): Yes:\_\_\_\_\_ No:\_\_\_\_\_\_ | | | | | | |
| Start Date: | End Date: | | | Medication Must be taken on *(circle one)*:  Field trips Does not apply | | |

**Licensed prescriber signature is required for all prescription medications and non-prescription medications to be given more than 3 consecutive days.**

|  |  |
| --- | --- |
| Physician/Licensed Prescriber Name: | Phone: |
| Signature: | Date: |

Authorized school personnel have permission to assist my child in taking the medication listed above while at school. I have read and accept the procedures listed for Administering Medications to Students. I authorize a representative of the school to share information regarding this medication with the licensed prescriber. I understand that MCPS Board and the employees are not responsible for the effects of the medication administered.

|  |  |  |
| --- | --- | --- |
| Date: | Parent/Guardian Signature: | |
| Cell Phone: | | Work Phone: |
| Emergency Phone/Contact Person: | | |

Clinic Use Only

|  |  |  |  |
| --- | --- | --- | --- |
| Date Medication Received: | Amount Received: | Parent/Guardian Initials:\_\_\_\_\_\_\_\_  Staff Initials:\_\_\_\_\_\_\_\_ | Expiration Date: |
| Date Medication Returned: | Amount Returned: | Parent/Guardian Initials:\_\_\_\_\_\_\_\_  Staff Initials:\_\_\_\_\_\_\_\_ |