Reg. No. 400-23

Clear Form

FREDERICK COUNTY PUBLIC SCHOOLS/FREDERICK COUNTY HEALTH DEPARTMENT

MEDICATION AUTHORIZATION FORM

This order is valid only for the current school year_____(Including Summer Session)

A new *Medication Authorization 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.

- All sections of this medication form must be completed for staff to administer required medication.
- Carefully review the reverse side of this form before completion.

Name:	***Date of Birth:***	***Grade:***

HEALTH CARE PROVIDER AUTHORIZATION

Diagnosis or Condition for which medication is being administered:

Antihistamine Use Only: **Check Condition(s) below that apply**.

☐ Potential for Anaphylaxis

☐ Seasonal/Environmental Allergies **OR** Other (specify): _____

To be administered as indicated in the appropriate *Administration of Antihistamine* section below

Allergies/Allergens:

Name of Medication	**Total Dose to be Administered:**	**Route:**
_____ ☐ May substitute generic	☐ _____ mg ☐ _____mcg ☐ _____units	☐Oral ☐Other_____

Time of Administration:	***If PRN, frequency:***

Additional Instructions:

ADMINISTRATION OF ANTIHISTAMINE

***Potential for Anaphylaxis**	***Seasonal/Environmental Allergies OR Other**
Complete if administering antihistamine as an <u>adjunct</u> treatment for the potential for anaphylaxis. Administer once immediately following ingestion of or contact with allergen specified above **Parent/guardian will be notified to pick student up from school**	**Complete if administering for mild allergy symptoms only.** Administer for mild allergy symptoms that which include: • Nose: itchy runny nose, sneezing • Skin: few localized hives, mild itching • Gut: mild nausea, discomfort • Other (specify):

Possible Medication Side Effects:

☐ None expected ☐ Specify: _____

Health Care Provider Stamp

Health Care Provider's Name/Title: (Please Print)

Telephone:	Fax:

Address:

Health Care Provider's Signature: *Date:*

PARENT/GUARDIAN AUTHORIZATION

I request designated personnel to administer the medication as prescribed by the health care provider above. I certify that I have legal authority to consent to the administration of medication at school and understand that the health care provider will be contacted if questions arise regarding the student's medication order or the medical condition for which the order is prescribed.

Primary Contact Phone:	*2nd Phone:*

Parent/Guardian Signature: *Date:*

REGISTERED NURSE REVIEW / AUTHORIZATION

RN Signature: *Date:*

IMPORTANT INFORMATION
for Parents/Guardians and Health Care Providers

1. Please give your child needed medication at home if at all possible.

2. It is required that the first full day's (24 hours) dose of any new medication be given at home. If unsure, follow the recommendation of health care provider about attending school during the first 24 hours.

3. If it is ***absolutely necessary*** for the student to take prescription, over-the counter or alternative medication at school or on field trips this "Medication Authorization Form" must be completed for each medication and **must be** submitted to FCHD school health staff prior to medication being given at school.

4. Medications:
   a. Prescription medication(s) must be in a container labeled by the pharmacist with the student's name, prescriber's name, name of medication, dosage, route, directions for administration, conditions for storage, prescription date and expiration date. *Maryland law allows prescription medication to be used only for 1 year beyond date of issue or until the expiration date indicated on the medication—whichever comes first*.
   b. Over-the-counter medication(s) must be provided to the school in the original sealed container.

5. Prescription information on label must match the Health Care Provider Authorization information on the Medication Authorization Form.

6. Parent/guardian responsibilities:
   a. Provide a new medication prior to the expiration date on the pharmacy label or the over-the-counter medication container.
   b. Provide the medication(s) for the duration of the order.
   c. Bring the medication to FCHD school health staff. FCPS Regulation 400-23 states that students are not permitted to transport medications, unless authorized to self-carry.
   d. Retrieve any unused or discontinued medication(s). No medications will be sent home with students.

7. Student Self-Carry and/or Self-Administer:
   a. The health care provider and school registered nurse must indicate whether the student is competent to self-administer and/or self-carry, if needed.
   b. Students may self-carry **emergency medications** only.

8. Antihistamines such as Diphenhydramine (i.e. Benadryl):
   a. Antihistamines are **not** used for the emergency treatment of severe life threatening allergies.
   b. If a student has a health care provider order for the use of an antihistamine, such as Diphenhydramine, in addition to the emergency medicine, epinephrine (i.e. EpiPen) for a life threatening allergy, antihistamine will not be routinely available during bus transportation to and from school. Allergen exposures on the bus will be handled as an emergency and the ***Authorization for Management of Anaphylaxis*** orders will be executed.
   c. For student safety, antihistamines will be routinely stored and administered in the health room.

9. The school registered nurse must review and approve these forms prior to administration.