Student Medication Authorization

Form 8

THE ROMAN CATHOLIC ARCHDIOCESE OF WASHINGTON- CATHOLIC SCHOOLS (MD/DC)

Maryland State Department of Education Office of Child Care
Medication Administration Authorization Form

NOTE: This is a release and indemnification agreement authorizing the administration of medication. It is NOT an authorization for an inhaler or Epinephrine. See form 9 (Asthma Medication Authorization Form) for an inhaler or Form 6 (Allergy Agreement and Action Plan).

This form must be completed fully in order for Child Care Providers/staff to administer the required medication. **This authorization is NOT TO EXCEED 1 YEAR.**
This form is required for both prescription and non-prescription/over-the-counter (OTC) medications.
Prescription medication must be in a container labeled by the pharmacist or prescriber.
Non-prescription/OTC medication must be in the original container with the label intact per COMAR.

Place Child's Picture Here (optional)

PRESCRIBER'S AUTHORIZATION

Child's Name:_____Date of Birth: ____/_____/_____

Medication and Strength	Dosage	Route/Method	Time & Frequency	Reason for Medication

Medications shall be administered from:____/____/_____ to ____/____/_____

If PRN, for what symptoms, how often and how long_____

Possible side effects and special instructions:_____

Known Food or Drug Allergies: ☐ Yes ☐ No If yes, please explain:_____

For School Age children only: The child may self-carry this medication: ☐ Yes ☐ No

The child may self-administer this medication: ☐ Yes ☐ No

PRESCRIBER'S NAME/TITLE		Place Stamp Here (Optional)
TELEPHONE	FAX	
ADDRESS		

PRESCRIBER'S SIGNATURE (Parent/guardian cannot sign here) (original signature or signature stamp only) | **DATE** (mm/dd/yyyy)

PARENT/GUARDIAN AUTHORIZATION

I authorize the child care staff to administer the medication or to supervise the child in self-administration as prescribed above. I attest that I have administered at least one dose of the medication to my child without adverse effects. I certify that I have the legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period an authorized individual must pick up the medication; otherwise, it will be discarded. I authorize child care staff and the authorized prescriber indicated on this form to communicate in compliance with HIPAA. I understand that per COMAR 13A.15, 13A.16, 13A.17, and 13A.18, the child care program may revoke the child's authorization to self-carry/self-administer medication. **School Age Child Only: OK to Self-Carry/Self-Administer ☐ Yes ☐ No**

PARENT/GUARDIAN SIGNATURE	DATE (mm/dd/yyyy)	INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION
CELL PHONE #	HOME PHONE #	WORK PHONE #

CHILD CARE STAFF USE ONLY

Child Care Responsibilities:

1. Medication named above was received. Expiration date _____ ☐ Yes ☐ No
2. Medication labeled as required by COMAR. ☐ Yes ☐ No
3. OCC 1214 Emergency Form updated. ☐ Yes ☐ No ☐ N/A
4. OCC 1215 Health Inventory updated. ☐ Yes ☐ No ☐ N/A
5. Individualized Treatment/Care Plan: Medical/Behavioral/IEP/IFSP. ☐ Yes ☐ No ☐ N/A
6. Staff approved to administer medication is available onsite, field trips ☐ Yes ☐ No

Reviewed by (printed name and signature):	DATE (mm/dd/yyyy)

Maryland State Department of Education Office of Child Care
MEDICATIONADMINISTRATION LOG

Each administration of a medication to the child, whether prescription or non-prescription, including self-administration of medication by a child, shall be noted in the child's record. Keep this form in the child's permanent record as required by COMAR. Print additional copies of this page as needed.

Child's Name:				**Date of Birth:**	
Medication Name:				**Dosage:**	
Route:				**Time to Administer:**	
DATE ADMINISTERED	**TIME**	**DOSAGE**	**ROUTE**	**REACTIONS OBSERVED (IF ANY)**	**SIGNATURE**

OCC 1216 REVISED SEPTEMBER 2022 - all previous editions are obsolete

School Based Checklist: To be completed by the School Nuse and Principal

Check, as appropriate:

☐ Licensed Health Care Provider (LHCP) and Parent Information are completed including signature. (It is acceptable if the LHCP sections are written on the LHCP stationery or prescription pad).

☐ Medication is appropriately labeled. _____ Date by which any unused medication is to be collected by the parent (within one week after expiration of the medication order or on the last day of school).

Signature of Nurse:_____Date: _____

Signature of Principal:_____Date: _____

PARENT INFORMATION ABOUT MEDICATION PROCEDURES

To be completed by the parent or gaurdian

1. In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined here and in the Archdiocese of Washington Catholic Schools Policies and district or state guidelines.
2. Schools do NOT provide medication for students use.
3. Medication should be taken at home whenever possible. The first dose of any new medication must be given at home.
4. Medication Authorization forms are required for each prescription and over-the-counter (OTC) medication administered in school.
5. All medication taken in school must have a parent/guardian signed authorization. Prescription medications, herbals and OTC medications also require a licensed healthcare provider's (LHCP) written order. No medication will be accepted by school personnel without the accompanying complete and appropriate medication authorization form.
6. All Over the Counter (OTC) medication must be in the original, sealed container with the name of the medication and its expiration date clearly visible. Parents/guardians must label the original container of the OTC with:
   - Name of student
   - Exact dosage to be taken in school
   - Frequency or time interval dosage is to be administered
7. The parent or guardian must transport medications to and from school.
8. Medication must be kept in the school health office, or other principal approved location, during the school day. All medication will be stored in a locked cabinet or refrigerator, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry a medication (inhaler, Epi-pen). If the student self carries, it is advised that a backup medication be kept in the clinic.
9. Parents/ guardians are responsible for submitting a new medication authorization form to the school at the beginning of the school year and each time there is a change in the dosage or the time of medication administration.
10. A Licensed Health Care Provider (LHCP) may use office stationery, prescription pad or other appropriate documentation in lieu of completing Part II. The following information written in lay language with no abbreviations must be included and attached to this medication administration form. Signed faxes are acceptable.

    - Student name
    - Date of Birth
    - Diagnosis
    - Signs or symptoms
    - Name of medication to be given in school
    - Exact dosage to be taken in school
    - Route of medication
    - Common side effects
    - Time and frequency to give medications, as well as exact time interval for additional dosages
    - Sequence in which two or more medications are to be administered
    - Duration of medication order or effective start and end dates
    - LHCP's name, signature and telephone number
    - Date of order

11. All prescription medications, including physician's samples, must be in their original containers and labeled by a LHCP or pharmacist. Medication must not exceed its expiration date.
12. The student is to come to the clinic or a predetermined location at the prescribed time to receive medication. Parents must develop a plan with student to ensure compliance. Medication will be given no more than one half hour before or after the prescribed time.
13. Within one week after expiration of the effective date on the order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within the period will be destroyed.
14. Students are NOT permitted to self-medicate. The school does not assume responsibility for medication taken independently by the student. Exceptions may be made on case-by-case basis for students who demonstrate the capability to self-administer emergency life-saving medications (e.g. inhaler, EpiPen)

I hereby request designated _____ School personnel to administer medication
School Name

as directed by this authorization. I agree to release, indemnify, and hold harmless the Roman Catholic Archdiocese of Washington, the parish, school personnel, employees, or agents from lawsuits, claim expense, demand or action, etc., against them for helping my child use this medication. I have read the procedures outlined above and assume responsibility as required.

Name of Parent/ Guardian: _____ Phone: _____

Signature of Parent/ Guardian: _____ Date: _____