BALTIMORE LAB SCHOOL
THE DIFFERENCE IS EXTRAORDINARY

BALTIMORE LAB SCHOOL PRESCRIPTION MEDICATION CONSENT FORM

This order is valid only for school year (current) _____ including the summer session
This form must be completed fully in order to administer the required medication. A new medication administration 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.

Prescriber's Authorization

Name of Student: _____Date of Birth: _____ Grade: _____

Medication Name: _____Dose: _____

Time/frequency of administration: _____

Condition for which medication is being administered: _____

If PRN, frequency and for what symptoms: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

Medication shall be administered from: _____ to_____

Month / Day / Year Month / Day / Year

Prescriber's Name/Title:_____

(Type or print)

Telephone: _____FAX: _____

Address: _____

_____

Prescriber's Signature: _____Date:_____ (Use for Prescriber's Address Stamp)

(Original signature or signature stamp ONLY)

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded.
I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____Date: _____

Home Phone #: _____ Cell Phone #:_____ Work Phone:_____

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

Self -carry/self-administration of **emergency** medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self-carry/self-administration of emergency medication:

Prescriber's Signature: _____Date:_____

School RN approval for self-carry/self-administration of emergency medication:

School RN Signature: _____Date:_____

Order reviewed by the School RN: _____

Signature/ Date

ADDITIONAL MEDICATION

Name of Student: ____

Medication Name: ______________________________Dose: ______________

Time/frequency of administration: ________________________________

Condition for which medication is being administered: ______________________

If PRN, frequency and for what symptoms: ___________________________

Relevant side effects: ☐ None expected ☐ Specify: _____________________

Medication shall be administered from: _________________ to_________________

Month / Day / Year Month / Day / Year

Prescriber's Name/Title:____

Prescriber's Signature: ________________________________Date:__________

ADDITIONAL MEDICATION

Name of Student: ____

Medication Name: ______________________________Dose: ______________

Time/frequency of administration: ________________________________

Condition for which medication is being administered: ______________________

If PRN, frequency and for what symptoms: ___________________________

Relevant side effects: ☐ None expected ☐ Specify: _____________________

Medication shall be administered from: _________________ to_________________

Month / Day / Year Month / Day / Year

Prescriber's Name/Title:____

Prescriber's Signature: ________________________________Date:__________

ADDITIONAL MEDICATION

Name of Student: ____

Medication Name: ______________________________Dose: ______________

Time/frequency of administration: ________________________________

Condition for which medication is being administered: ______________________

If PRN, frequency and for what symptoms: ___________________________

Relevant side effects: ☐ None expected ☐ Specify: _____________________

Medication shall be administered from: _________________ to_________________

Month / Day / Year Month / Day / Year

Prescriber's Name/Title:____

Prescriber's Signature: ________________________________Date:__________

Order reviewed by the School RN: ____________________________________

Signature/ Date