Prince George's County Public Schools

Prescriber's Medication Order Form

Prescription and Non-Prescription Medication

ONE medication per form

This order is valid ONLY for school year (current) _____ **including the ESY/summer session.**

Name of School: _____

FOR COMPLETION BY PARENT(S)/GUARDIAN(S):

Full Name of Student: _____   Date of Birth: _____   Grade: _____

Known Allergies: ☐ None   ☐ Specify: _____

- **I** hereby authorize the medication described below to be administered as directed by my child's health care prescriber.
- **I** understand that the prescriber will be called if a question arises about my child's medication as allowed by HIPAA.
- **I** understand that <u>ALL</u> medications must be labeled with the name of the medication, name of the student, name of the prescriber, date, and directions for administration <u>and</u> prescription medication(s) must be labeled by a registered pharmacist.
- **I** understand that I must supply the school with the equipment/supplies needed to administer the medication.
- **I** understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded.
- **I** understand 911 will be called immediately if a medical condition warrants it.

Parent/Guardian Signature: _____   Date: _____

Home phone #: _____   Cell phone #: _____   Work phone #: _____

FOR COMPLETION BY PRESCRIBER

Medication Name: _____   Dose: _____   Route: _____

Reason for medication: _____

Time of day medication is to be given: _____   Frequency: _____

If PRN, for what symptoms: _____

Side effects: _____

Special Instructions: _____

Date medication began: _____   Date medication discontinued: _____
 Month/ Day/ Year   **Month/ Day/ Year**

Prescriber's Name / Title: _____
 (Please print or type)

Telephone: _____   FAX: _____

Address: _____

Prescriber's Signature: _____   Date: _____
 (Original Signature or signature stamp only)

Order reviewed by RN / LPN: _____   Date: _____

Medication Administration Record (MAR)

Student Name: _____   DOB: _____   Allergies: _____

Medication, Dose, Route, Time/Frequency	Mo/Yr	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Aug																																
	Sep																																
	Oct																																
	Nov																																
	Dec																																
	Jan																																
	Feb																																
	Mar																																
	Apr																																
	May																																
	Jun																																
	Jul																																

** Circle around box indicates SEE PROGRESS NOTE**

* Disposition Code: **A** = Absent   **R** = Refused   **NMA** = No Medication Available   **D** = Destroyed   **X** = School Closed

Signature(s) of Medication Administrators	Position	Initials

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