Prince George's County Public Schools

Prescriber's Medication Order Form

Inhaler or Nebulizer

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 ALL medications must be labeled with the name of the medication, name of the student, name of the prescriber, date, and directions for administration and 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: _____

Type of Devise: ☐ Inhaler ☐ Nebulizer ☐ Other _____

Frequency medication to be given: _____

PRN for: **Wheezing, Coughing, SOB, or Peak Flow Readings** in the yellow or red zone**,** ☐ **Other**: _____

Side effects: _____

Date medication began: _____ Date medication discontinued: _____

Month/ Day/ Year **Month/ Day/ Year**

Is student capable of self-administering the medication by device? ☐ Yes ☐ No

Should student carry medication with him/her? ☐ Yes ☐ No

Prescriber's Signature: _____ Date: _____

(Original Signature or signature stamp only)

Prescriber's Name/Title: _____ Address: _____

(Please print or type)

Telephone: _____ FAX: _____

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

Self-carry/self-administration of **emergency** medication **MUST** be authorized by the prescriber and supported by the school nurse's assessment according to Medication Administration policy #5163. *** self-carry and self-administer: ☐ Yes ☐ No Signature of PGCPS RN/LPN: _____

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																															
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	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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