Board of Education of Allegany County

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Superintendent of Schools

CUMBERLAND, MARYLAND 21502

PHYSICIAN'S AUTHORIZATION

DATE OF ORDER _____ GRADE _____

NAME OF STUDENT _____ D.O.B. _____

SCHOOL _____Parent/Guardian phone #_____

*MEDICATION _____

DOSAGE _____

TIME OF ADMINISTRATION _____

ROUTE OF ADMINISTRATION_____

DURATION OF ADMINISTRATION _____

POSSIBLE SIDE EFFECTS:

* *EPI-PEN/ INHALER*
MAY MEDICATION BE SELF-ADMINISTERED? YES ____ NO ____ **(Grade 6-12)**
MAY MEDICATION BE SELF-CARRIED? YES ____ NO ____ ***(Must fill out top- side 2)***
MAY BE ADMINISTERED ON FIELD TRIPS? YES ____ NO ____ ***(Must fill out bottom- side 2)***

SIGNATURE OF PHYSICIAN _____

TELEPHONE NUMBER _____

PARENTAL PERMISSION

I hereby give my permission for _____

to take _____ at school as ordered by the physician, nurse practitioner or midwife, dentist or chiropractor. I understand that it is my responsibility to furnish this medication. I further understand that any school nurse or employee who administers any drug to my child, in accordance with written instructions from the prescriber, shall not be liable for damages as a result of adverse drug reaction by my child due to the administration of the drug.

I understand that the medication must be brought to school in the original container appropriately labeled. This includes my child's name, name of medication, dosage, time of administration, route, name of prescriber, date of medication order, and expiration date of drug.

_____ _____
SIGNATURE PARENT/GUARDIAN DATE

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*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.

I have instructed the student in the proper way to use his/her ☐ Inhaler ☐ Epi-pen

☐ It is my professional opinion that the student **should** be allowed to carry and use that medication by him/herself.

Physician Signature **Date**

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

School Nurse Signature **Date**

SIGNATURE PARENT/GUARDIAN DATE

*FIELD TRIP AUTHORIZATION

☐ **EPI-PEN**

Give Epi Pen if any of the following symptoms occur:

*MOUTH itching & swelling of lips, tongue or mouth
*THROAT itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
*SKIN hives, itchy rash, and/or swelling about the face or extremities.
*GUT nausea, abdominal cramps, vomiting, and/or diarrhea
*LUNG shortness of breath, repetitive coughing, and/or wheezing.

Student must be transported *by ambulance* to the hospital if Epi-Pen is given

☐ **INHALER**

Student to use inhaler if any of the folling symptoms occur:

* Shortness of breath
* Repetitive coughing and/or wheezing

12/3/08
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