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: ___________________