

Attachment I

MONTGOMERY COUNTY PUBLIC SCHOOLS
MONTGOMERY COUNTY DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Rockville, Maryland 20850

AUTHORIZATION TO ADMINISTER
PRESCRIBED MEDICATION
Release and Indemnification Agreement

PART I—TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize Montgomery County Public Schools (MCPS) and Montgomery County Department of Health and Human Services (MCDHHS) personnel to administer prescribed medication as directed by the physician (Part II below). I agree to release, indemnify, and hold harmless MCPS and MCDHHS and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering prescribed medication to this student, provided MCPS and MCDHHS staff are following the physician's order as written in Part II below. I have read the procedures outlined on the back of this form and assume the responsibilities as required.

Student: _____ Birthdate: ___/___/___ School: _____

Prescription: Renewal New If new, the first full day's dosage was given at home on: ___/___/___

List all medication(s) student is taking, including over-the-counter medication(s): _____

Parent/Guardian Signature Phone Number Date

PART II—TO BE COMPLETED BY THE PHYSICIAN

The Montgomery County Department of Health and Human Services and the Montgomery County Public Schools discourage the administration of medication to students in school during the school day. Any necessary medication that possibly can be administered before and after school should be so prescribed. Only non-parenteral medications are administered except in specific emergency situations. School personnel will, when it is absolutely necessary, administer medication to students during the school day and while participating in outdoor education programs and overnight field trips, according to the procedures outlined on the back of this form.

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

Name of Medication: _____ Diagnosis: _____
Trade name and/or generic

Dosage: _____ Time(s) To Be Given At School: _____

Route of Administration: _____ Effective Dates: From ___/___/___ To ___/___/___

Side Effects: _____

If PRN, specify:

When indicated (signs/symptoms) _____

Frequency of administration _____

Physician's Name (print/type) Physician Signature Phone Number Date

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

Self-carry/self-administration of **emergency** medication such as inhalers and EpiPens® must be authorized by the prescriber and be approved by the school nurse according to the State medication policy:

Prescriber's authorization for self-carry/self-administration of emergency medication _____
Signature Date

School RN approval for self-carry/self-administration of emergency medication _____
Signature Date

PART III—TO BE COMPLETED BY THE PRINCIPAL OR SCHOOL NURSE

Check as appropriate:

- Parts I and II above are completed, including signatures. (It is acceptable if all items of information in Part II are written on the physician's stationery/prescription blank.)
- Prescription medication is properly labeled by a pharmacist.
- Medication label and physician order are consistent.
- Over-the-counter medication is in an original container with the manufacturer's dosage label and safety seal intact.

___/___/___ Date any unused medication is to be collected by the parent or guardian (within one week after expiration of the physician's order).

Principal/School Nurse Signature Date