ST. MARY'S COUNTY PUBLIC SCHOOLS

Department of Student Services/St. Mary's County Health Department

PARENT(S)/LEGAL GUARDIAN(S) AND PHYSICIAN/PRESCRIBER AUTHORIZATION – MEDICAL PROCEDURES

This order is valid only for the school year (current) _____ including the summer session.

School: _____

This form must be completed fully in order for schools to administer the required medical procedure/treatment. A new medical procedure form must be completed at the beginning of each school year for each treatment, and each time there is a change in the dosage, type, and route administration.

- Medical equipment must be provided by the parent(s)/legal guardian(s).
- An adult must bring the medical equipment to the school.
- The school nurse (RN) will call the prescriber, as allowed by HIPPA, if a question arises about the child and/or the child's medical procedure/treatment.

Prescriber's Authorization

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

Condition for which medical treatment is being administered: _____

Medical Procedure: _____

(Give detailed instructions or attach a standard protocol to be followed at school)

Medication Name: _____ Dose: _____ Route: _____

Time/Frequency of Administration: _____ If PRN, Frequency: _____

If PRN, for What Symptoms: _____

Equipment Needed: _____

Relevant Side Effects: ☐ None Expected ☐ Specify: _____

Duration of Administration: _____

Prescriber's Name/Title: _____

(Type or Print)

Telephone: _____ FAX: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____

(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): _____ for the above medical procedure on: _____

(Date)

A verbal order was taken by the school LPN (Name): _____ for the above medical procedure on: _____

(Date)

PARENT(S)/LEGAL GUARDIAN(S) AUTHORIZATION

I/We request designated school personnel to administer the medical procedure/treatment as prescribed by the prescriber. I/We certify that I/we have legal authority to consent to a medical procedure for the student named above, including the administration of a medical treatment at school. I/We understand that it is my/our responsibility to furnish all information and equipment required to administer this procedure at school. I/We further understand that any school employee who administers the medical procedure to my/our child, in accordance with written instructions from the prescriber and St. Mary's County Public Schools, shall not be liable for damages as a result of an adverse reaction suffered by my/our child due to the procedure. I/We understand that at the end of the school year, an adult must pick up the medical equipment, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPPA.

Parent(s)/Legal Guardian(s) Signature: _____ Date: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Order Reviewed by the School RN: _____ **Date:** _____

Signature