HCPS

HARFORD COUNTY PUBLIC SCHOOLS
MEDICATION POLICY AND PERMISSION FORM

Dear Parent/Legal Guardian:

This form must be completed and signed by you and your student's health care provider for all prescription and over the counter medications.

- A new form is needed each new school year and for all changes in medication, dose or time.
- The medication must be brought to school by a parent/guardian or responsible adult. Students are not permitted to carry medication on the school buses or the school grounds. Under extenuating circumstances, there may be exceptions. This is for the safety of all students.
- Prescription medications must be in a labeled prescription container with specific instructions.
- Over the counter medications must be in the original container.
- All medication not picked up by the last day of school will be destroyed.

HEALTH CARE PROVIDER INSTRUCTIONS FOR GIVING MEDICATION IN SCHOOL

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

Allergies: _____

Medication Name: _____ Route: _____

Reason for Administration: _____

Exact Dose to be Given **(Must specify in mg and/or # of puffs)** _____

Time/Frequency of Administration: _____ If prn, frequency: _____

If prn, for what symptoms: _____

Duration of Administration: _____

Relevant Side Effects: None Expected _____ Specify: _____

Any additional instructions or follow-up: _____

Health Care Provider Signature: **(no stamps)** _____ Date: _____

Health Care Provider Name Printed _____

Phone: _____ Fax: _____

PARENT/LEGAL GUARDIAN AUTHORIZATION

- I request designated school personnel to administer the medication as prescribed by the above health care provider.
- I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school.
- I authorize the school nurse to communicate with the health care provider as needed.

Early dismissal days: Administer medication _____ Omit medication _____

Delayed opening days: Administer medication at usual time: Yes ☐ No ☐ Alternate time to administer _____

Parent/Legal Guardian Signature:_____

Date: _____ Phone: _____

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RECORD OF MEDICATION RECEIVED/RETURNED

DATE	NAME OF MEDICATION	AMOUNT ON HAND	AMOUNT OF MEDICATION RECEIVED (INDICATE DOSE)	MEDICATION RETURNED TO PARENT/GUARDIAN	PARENT/GUARDIAN INITIALS	SCHOOL NURSE INITIALS

PARENT/GUARDIAN SIGNATURE:_____ INITIALS:_____

PARENT/GUARDIAN SIGNATURE:_____ INITIALS:_____

SCHOOL NURSE SIGNATURE:_____ INITIALS:_____

SCHOOL NURSE SIGNATURE:_____ INITIALS:_____

SCHOOL NURSE SIGNATURE:_____ INITIALS:_____