Grace Christian School
Before & After Care/Summer Camp
7210 Race Track Road * Bowie, MD 20715 * 301-262-0158

MEDICATION ADMINISTRATION AUTHORIZATION FORM

<u>This form must be fully completed in order for the GCS School Office to administer both prescription and over the counter medication.</u> A separate medication administration authorization form must be completed for each medication at the beginning of each school year and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in an original container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- An adult must bring the medication to school and give it to a staff member.
- The office staff will call the prescriber, as allowed by HIPAA, if a question arises about the student and/or the student's medication.
- No medication (Tylenol, Aspirin, Allergy Medicine) will be given out by the school office unless the medication is directly given by the parent/guardian and a Medication Administration Authorization Form is completed.
- A student may carry an inhaler if approved by doctor. All other medications will be kept under lock in school office.

Prescriber's Authorization

Name of Student: _____
Condition for which medication is being administered: _____
_____
Medication Name: _____
Dose: _____Route:_____
Time/frequency of administration: _____
If PRN, frequency: _____
If PRN, for what symptoms: _____
Relevant side effects: □ None expected □ Specify: _____
_____
_____
This medication shall be administered during the school year while this student is attending Grace Christian School from: _____/_____/_____ to _____/_____/_____
Month / Day / Year *Month / Day / Year*
Is the student allowed to self-medicate? *(Inhalers only)* Yes No
Prescriber's Name/Title: _____
Practice Name: _____
Telephone: _____FAX: _____
Address: _____
Doctor's Signature: _____Date: _____

over

PARENT/GUARDIAN AUTHORIZATION

I/We request designated GCS personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of each school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school office staff and school prinicipal to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____
Date: _____

*This form is a "GCS version" of the Maryland School Medication Administration Authorization Form required by all Maryland public schools.

For GCS Office Staff Use Only:

Form Rec'd by:_____ Med Received by:_____
Date:_____ Date:_____
Other notes:_____
_____
_____
_____
_____
_____

Medication Returned To Parent/Guardian ☐ Medication Discarded ☐
By: _____ Date:_____ By: _____ Date:_____