

CARROLL COUNTY PUBLIC SCHOOLS MEDICATION FORM

Name: _____ D.O.B.: _____ Allergies: _____ Grade/Teacher: _____ Bus # _____

Medication: _____ Strength: _____ Dosage: _____ Time: _____ Expiration Date: _____

From: _____ To: _____ Reason: _____ Side Effects: _____

If medication administration is necessary during school hours, this form must be completed before any representative of the school can administer prescription or non-prescription medications to your child. **Special Notes:**

1. Medications must be in original container marked specifically for student.
2. All homeopathic/herbal prescription AND non-prescription medicines require a parent AND physician/dentist or nurse practitioner signature. (Physician's Assistant signature NOT acceptable) *EXCLUSION: Ibuprofen and Acetaminophen in age appropriate doses only.
3. Medications are not to be transported by students. This is in violation of our Drug-Alcohol policy. Leftover medication will be returned to parent, guardian or designated adult. Unused, unclaimed, or expired medicines will be destroyed at the end of the school year.
4. Medication orders are only valid for the current school year including the summer session.

* (Maryland law allows prescription medication to be used only for 1 year beyond date of issue or expiration date indicated on the medication – whichever comes first.)

I authorize and request representatives of Carroll County Public Schools to administer the medication listed above, in doing so, relieve them of ill effects resulting from the administration of medication to my child. I also give them permission to contact the physician for any questions regarding the administration of this medication.

Parent/Guardian Signature: _____ Physician Signature: _____ Physician's Phone # _____

Inhaler Release: (It is the student's responsibility to report usage to the school nurse)

This section must be completed in addition to above for those students who request permission to carry their own inhaler.

We acknowledge that the student named above has been instructed as to the proper use, understands the purpose and the appropriate method as well as the frequency of use of their inhaler. We request that the student may be able to carry their inhaler on their person or secured in their locker.

Parent/Guardian Signature: _____ Physician Signature: _____

Codes (chart reason)

- | | | |
|---------------------|------------------|--------------------|
| A – Absent | F – Field Trip | N – None Available |
| C – School Closed | H – Holiday | O – No Show |
| E – Early Dismissal | L – Late Opening | W – Dose Withheld |

Initial	Name	Initial	Name
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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