Archbishop Curley High School
3701 Sinclair Lane
Baltimore, MD 21213
(410) 485-5000

MARYLAND STATE
SCHOOL MEDICATION ADMINISTRATION
AUTHORIZATION FORM
This order is valid only for the academic year 2025-2026
EXPIRES JUNE 30, 2026

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

* Prescription medication must be in a 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 the school.
* The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

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

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: _____

Medication shall be administered from: _____to_____
Month / Day / Year Month / Day / Year

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 medication on (Date): _____

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school 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 the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature**:** _____ Date: _____
Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF ADMINISTRATION OF EMERGENCY MEDICATION - AUTHORIZATION/APPROVAL

Self carry/self administration of emergency medication may be authorized by the prescriber and must 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

_____

Order reviewed by the school RN: _____
Signature Date
