City of Rockville Get Into It

Program Name:______________________________

Program Location:___________________________

One form per site

☐ Prevention/Action Plan for medication and/or emergency care attached.

MEDICATION ADMINISTRATION AUTHORIZATION FORM

This form must be completed fully in order for after-school operators and staff members to administer the required medication or for the child to self-administer 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.
- Nonprescription medication must be in the original container with the instructions for use. Nonprescription medication includes vitamins, homeopathic, and herbal medicines.
- An authorized individual must bring the medication to the after-school program and give the medication to an adult staff member.
- Parents should provide a physician authorized prevention/action plan(s) for medication and/or emergency care

I. PRESCRIBER'S AUTHORIZATION

1. CHILD'S NAME		2. DATE OF BIRTH ____/____/________ Month Day Year
3. CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:		4. EMERGENCY MEDICATION [ ] YES ***-If yes, see Section III below***. [ ] NO
5. MEDICATION NAME	6. DOSE	7. ROUTE

8. TIME/FREQUENCY OF ADMINISTRATION	9. IF PRN, FREQUENCY

10. IF PRN, FOR WHAT SYMPTOMS

11. KNOWN SIDE EFFECTS SPECIFIC TO CHILD

12. MEDICATION SHALL BE ADMINISTERED during the year in which this form is dated in 14b below unless more restrictive dates are specified in 12a and 12b. This authorization is ***NOT TO EXCEED 1 YEAR***.	12a. FROM ____/____/________ Month Day Year	12b. TO ____/____/________ Month Day Year

13. PRESCRIBER'S NAME/TITLE			This space may be used for the Prescriber's Address Stamp
TELEPHONE	FAX		
ADDRESS			
CITY	STATE	ZIPCODE	

14a. PRESCRIBER'S SIGNATURE ***(Parent/guardian cannot sign here)*** *(ORIGINAL SIGNATURE OR SIGNATURE STAMP ONLY)*	14b. DATE

II. PARENT/GUARDIAN AUTHORIZATION

I request the authorized after-school program operator, staff member or volunteer to administer the medication or supervise the child in self-administration as prescribed by the above authorized prescriber. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I understand that at the end of the authorized period, an authorized individual, as listed in 15c below, which may include the child, must pick up the medication, otherwise it will be discarded. I authorize program personnel and the authorized prescriber indicated on this form to communicate in compliance with HIPAA.

15a. PARENT/GUARDIAN SIGNATURE	15b. DATE	15c. INDIVIDUAL(S) AUTHORIZED TO PICK UP MEDICATION
15d. HOME PHONE #	15e. CELL PHONE #	15f. WORK PHONE #

III. AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY (OPTIONAL)

This section should only be completed if this medication is approved for self-administration. Self-carry is only permitted for emergency medications such as inhalers and epinephrine. Both the prescriber and the parent/guardian must consent to self-administration below. However, after-school program operators are not required to permit self-administration or self-carry.

I authorize self-administration of the above listed medication for the child named above under the supervision of the after-school program operator, a designated staff member or volunteer. If indicated below, the child named above may self-carry emergency medication.

16a. PRESCRIBER'S SIGNATURE authorizing self-administration	16b. SELF-CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] N/A - Not emergency medication	16c. DATE
17a. PARENT/GUARDIAN'S SIGNATURE authorizing self-administration	17b. SELF-CARRY EMERGENCY MEDICATION (Check One) [ ] YES [ ] NO [ ] N/A - Not emergency medication	17c. DATE

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I. FACILITY RECEIPT AND REVIEW			
MEDICATION RECEIVED FROM			DATE
PLAN OF ACTION RECEIVED [ ] YES [ ] NO [ ] N/A		HEALTH SUPERVISOR NOTIFIED [ ] YES [ ] NO	
MEDICATION RECEIVED BY	PERSON’S SIGNATURE		DATE

II. MEDICATION ADMINISTRATION RECORD	
Each administration of the listed medication shall be noted on the child’s record below. Each nonprescription and prescription medication requires a separate medication authorization form and the administration of the listed medication is required to be recorded on the corresponding administration record.	
Child’s Name:	**Date of Birth:**
Medication Name:	**Dosage:**
Route:	**Time(s) to Administer:**

DATE	TIME	DOSAGE	REACTION OBSERVED (IF ANY)	STAFF OR SELF ADMINISTERED	NAME OF INDIVIDUAL WHO ADMINISTERED OR SUPERVISED SELF-ADMINISTRATION