BALTIMORE
CITY HEALTH
DEPARTMENT

Bureau of School Health **Student Health Information Form**

This questionnaire is designed to aid school health staff in anticipating health concerns that may affect your child's safety or learning

(***PLEASE PRINT***) **School Year: 2020- 2021** School #: 301 Grade/Class: ____________

Student Name: ____________________ Birth Date: __________ ☐ Male ☐ Female

Address: ____________________ Zip Code: ________

Name of Parent/Guardian: ____________________ Relationship: ____________

Home #: ____________ Work #: ____________ Cell #: ____________

Name of Parent/Guardian: ____________________ Relationship: ____________

Home #: ____________ Work #: ____________ Cell #: ____________

Emergency Contact if parent/guardian cannot be reached

Name: ____________ Relationship: ____________ Phone #: ____________

Name: ____________ Relationship: ____________ Phone #: ____________

Name: ____________ Relationship: ____________ Phone #: ____________

MEDICAL

Student's Healthcare Provider/Clinic: ____________ Office #: ____________

Last Physical (Month/Year): ____________

DENTAL

Does your child have a dentist? ☐ Yes ☐ No Last Dental Visit (Month/Year): ____________

INSURANCE

Does the student have health insurance? ☐ Medical Assistance/MCHP ☐ Private ☐ No Insurance

MEDICAL HISTORY

Have you ever been told by a healthcare professional that your child has *(check all that apply)*:

☐ Asthma ☐ Seizure Disorder ☐ Bleeding Disorder ☐ ADD/ADHD ☐ Diabetes ☐ Bone/Muscle Disease ☐ Cancer
☐ Skin Condition ☐ Learning Disability ☐ Heart Condition ☐ Mental Health Condition (i.e. depression, anxiety, eating disorder)
☐ Speech/Language ☐ Other____________

Does your child experience any of the following *(check all that apply)*:

☐ Nose Bleeds ☐ Frequent Ear Aches or Ear Infections ☐ Overweight for Age ☐ Physical Disability ☐ Fainting Spells
☐ Frequent Headaches ☐ Frequent Stomach Aches ☐ Emotional Concerns ☐ Underweight for Age
☐ Other____________

ALLERGIES

☐ Food ☐ Drugs ☐ Animals ☐ Bees/Wasps ☐ Latex ☐ Molds ☐ Plants ☐ Environmental (dust, smoke, odors, etc.)

Please describe the allergic reaction and the treatment: ____________

MEDICATION

Does your child take any medication? ☐ Yes Medication Names: ____________ ☐ No

If medication is needed during the school day, please contact the School Health Staff for necessary authorization forms.

HEARING AND VISION

Do you have concerns about your child's hearing? ☐ Yes ☐ No Does your child wear hearing aids? ☐ Yes ☐ No

Do you have concerns about your child's vision? ☐ Yes ☐ No Does your child wear glasses or contacts? ☐ Yes ☐ No

Thank you for your cooperation in completing this form. The information you share will help us take better care of your child while he/she is in school.

Parent/Guardian Signature: ____________________ Date: ____________

 RETURN COMPLETED FORM TO HEALTH SUITE. PLEASE UPDATE IF INFORMATION CHANGES

BALTIMORE CITY HEALTH DEPARTMENT

Bureau of School Health

Medication/Treatment Supply List

Students who require medications and/or treatments during the school day must submit a Medication Administration Authorization Form completed by a healthcare provider and signed by their parent/guardian each school year (See attached *School Medication Administration Policy*).

The following is a list of the supplies needed to perform the treatment (procedure) your child's healthcare provider has ordered:

If your child has **Diabetes**, please provide the following items:

- Glucose Monitoring meter (must remain in school): drum or strips for code meter, lancets, insulin syringes or pen(s), and extra batteries
- Ketostix to test urine for ketones
- Fast acting insulin (Humalog, Novolog, Apidra, etc.) in a vial or insulin pen. Insulin must be in a pharmacy labeled box with student's name on it
- Glucagon (emergency medicine for loss of consciousness due to low blood sugar)
- Medic Alert bracelet or necklace (recommended)
- Sources of fast-acting carbohydrates:
  - At least 1 quart of a sugar beverage (i.e. orange juice, regular soda, etc.)
  - 1 tube cake- mate icing (not red)
  - Snack items (i.e. graham crackers, candy bars, glucose tablets)

If your child has **Asthma**, please provide the following items:

- Metered dose inhaler in pharmacy labeled box along with spacer
- Peak Flow Meter, if prescribed
  - ***Please Note: A metered dose inhaler with a spacer/chamber is the preferred method of administration. A nebulizer treatment can be used as an alternative if the student cannot use an inhaler correctly, or the inhaler is not effective within a specified amount of time.***

If your child requires **Gastrostomy tube feedings**, please provide the following items:

- Gastrostomy tube replacement kit
- Formula, feeding bag/ adapters, tubing
- Pump (if ordered)

If your child requires assistance with **Catheterization**, please provide the following items:

- Catheters
- Lubricant
- Cleaning solution

If your child has **Seizures,** please provide the following items:

- Diazepam Rectal Gel
- Vagus Nerve Stimulator (if applicable)

Other Medication or Durable Medical Equipment needed: ______________________

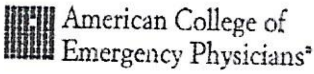
For questions or concerns, please call the school health staff at:

School #: 301　　　　Phone #: 410-396-0849.

_______________________　　　　_______________________

Registered Nurse　　　　Licensed Practical Nurse / School Health Aide

Emergency Information Form for Children With Special Needs


American College of Emergency Physicians®

American Academy of Pediatrics

Date form completed	Revised	Initials
By Whom	Revised	Initials

Last name:

Name: Birth date: Nickname:

Home Address: Home/Work Phone:

Parent/Guardian: Emergency Contact Names & Relationship:

Signature/Consent*:

Primary Language: Phone Number(s):

Physicians:

Primary care physician: Emergency Phone:

Fax:

Current Specialty physician: Emergency Phone:

Specialty: Fax:

Current Specialty physician: Emergency Phone:

Specialty: Fax:

Anticipated Primary ED: Pharmacy:

Anticipated Tertiary Care Center:

Diagnoses/Past Procedures/Physical Exam:

1.
2.
3.
4.

Synopsis:

Baseline physical findings:

Baseline vital signs:

Baseline neurological status:

*Consent for release of this form to health care providers

Last name:

Diagnoses/Past Procedures/Physical Exam continued:

Medications:

1.
2.
3.
4.
5.
6.

Significant baseline ancillary findings (lab, x-ray, ECG):

Prostheses/Appliances/Advanced Technology Devices:

Management Data:

Allergies: Medications/Foods to be avoided and why:

1.
2.
3.

Procedures to be avoided and why:

1.
2.
3.

Immunizations (mm/yy)

Dates						
DPT						
OPV						
MMR						
HIB						

Dates						
Hep B						
Varicella						
TB status						
Other						

Antibiotic prophylaxis: Indication Medication and dose

Common Presenting Problems/Findings With Specific Suggested Managements

Problem	Suggested Diagnostic Studies	Treatment Considerations

Comments on child, family, or other specific medical issues:

Physician/Provider Signature: Print Name:

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BALTIMORE CITY HEALTH DEPARTMENT

Bureau of School Health

Authorization to Administer Specialized Treatments/Procedures in School

This order is valid only for the (current) school year 2020 - 2021 including the summer session.

Student Name: ______________________________ Grade/Class: __________________ School # 301

Birth Date: ______________________________ School Year: 2020-2021

ENTERAL FEEDING	Description of Treatment/Procedure:
Medical Condition: ______________________	( ) PUMP ( ) GRAVITY TIME MAX – 1HR. Formula: ________________ Vol.: ________ Rate: _______ Water Vol.: _________ Tube Replacement: ( ) When no longer patent ( ) When dislodged Type of Tube: ____________ Size: ____________ Balloon Size: ________________ Specific Instructions: ____ Comments:
SUCTION	**Description of Treatment/Procedure:**
Medical Condition: ______________________	( ) Nasal ( ) Oral ( ) Pharyngeal ( ) Tracheostomy ( ) Bulb ( ) Catheter Size________________________________ ( ) Routine Time: __________________ ( ) PRN - Frequency:_______________ Specific Instructions: ____ Comments:
CATHETERIZATION	**Description of Treatment/Procedure:**
Medical Condition: ______________________	( ) Urethral ( ) Ostomy Catheter size________________________________ Time(s) in School: ____ Specific Instructions: ____ Comments:
OSTOMY CARE	**Description of Treatment/Procedure:**
Medical Condition: ______________________	( ) Colostomy ( ) Ureterostomy ( ) Gastrostomy ( ) Tracheostomy Type of Appliance: ________________ Specific Instructions: ________________ Comments:

______________________ DATE	______________________________ Healthcare Provider's Signature ______________________________ Type/Print Name/Address of Healthcare Provider	____________________ Office # ____________________ Fax #

PARENT/GUARDIAN AUTHORIZATION

I understand that designated school health services staff or their designee will administer the medication as prescribed by the above healthcare provider. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I acknowledge that the Registered Nurse (RN) can communicate with the healthcare provider as allowed by HIPAA. I authorize the RN to share this information with school staff that have a legitimate educational interest in my child.

Parent (Guardian) Signature: Relationship to Student: Date:

Date received in Health Suite: by:

Order reviewed by Registered Nurse (Print): Signature: Date:

Order Review (Print)______________________ Date: ________ Order Review (Print)______________________ Date: __________

BALTIMORE CITY HEALTH DEPARTMENT

Bureau of School Health

Allergy/Anaphylaxis Action Plan

This order is valid for School Year: 2020-2021 (including the summer session) School #: 301 Grade: ______

Student Name: ____________________ Birth Date: ____________ Weight: ________ lbs.

Allergy to: ____________________

Asthma: ☐ Yes (higher risk for a anaphylaxis in students with asthma and history of allergy) ☐ No

Symptoms		Action
1) Any SEVERE SYMPTOMS after suspected or known ingestion: One or more of the following: LUNG: Short of breath, wheeze, repetitive cough HEART: Pale, blue, faint, weak pulse, dizzy, loss of consciousness THROAT: Tight, hoarse, trouble breathing or swallowing MOUTH: Obstructive swelling (tongue and/or lips) Or combination of symptoms from different body areas: SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips), generalized flushing GI: Vomiting, diarrhea, cramping MENTAL: Uneasiness, agitation, panic 2) KNOWN INGESTION and PREVIOUS HISTORY OF ANAPHYLAXIS to the allergen (no symptoms need to be present) 3) Other: ____________	→	1. INJECT EPINEPHRINE IMMEDIATELY 2. Call 911 3. Begin monitoring (see box below) 4. Give additional medications if prescribed:* - Antihistamine - Inhaler (bronchodilator) if Asthma symptoms present * Antihistamines & inhalers or bronchodilators are not to be depended upon to treat or prevent a severe reaction (anaphylaxis).
1) MILD SYMPTOMS ONLY AND NO PREVIOUS HISTORY OF ANAPHYLAXIS: MOUTH: Itchy mouth SKIN: A few hives mild itching GI Mild nausea/discomfort 2) Other: ____________	→	1. GIVE ANTIHISTAMINE 2. Stay with student; alert healthcare provider and parent 3. If symptoms progress (see above), USE EPINEPHRINE 4. Begin monitoring (see box below)

HEALTHCARE PROVIDER'S AUTHORIZATION

Order 1: Medication Name: **Epinephrine Auto-Injector** Strength: ☐ **0.15 mg** or ☐ **0.3 mg**? Dose: 1 injection Route: IM

PRN & Frequency: ☐ May give 2nd injection if needed; for what symptoms?: ____________

Relevant side effects: ☐ None expected ☐ Specify: Tachycardia, palpitations, sweating, nausea, vomiting, difficulty breathing, paleness, dizziness, weakness, anxiety

☐ Student may self-carry EpiPen®/epinephrine auto-injector ☐ Student may self-administer EpiPen®/epinephrine auto-injector

Order 2: Medication Name: **Benadryl** (Diphenhydramine) Strength: ________ Dose: ______ Route: ______ PRN: _____

Frequency: __________ for what symptoms?: ____________

Relevant side effects: ☐ None expected ☐ Specify: ____________

Healthcare Provider's Name/title: ____________________
(Type or print)

Office #: ____________ FAX #: ____________

Address: ____________________

Healthcare Provider's Signature: ____________ Date: ________
Original (signature or signature stamp ONLY)

(Healthcare Provider's Office Stamp)

PARENT / GUARDIAN AUTHORIZATION

I understand that designated school health services staff or their designee will administer the medication as prescribed by the above healthcare provider. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I acknowledge that the Registered Nurse (RN) can communicate with the healthcare provider as allowed by HIPAA. I authorize the RN to share this information with school staff that have a legitimate educational interest in my child.

Parent/Guardian Signature: ____________ Date: ________ Emergency Phone #: ____________

Date received in health suite: ____________ by ____________

Reviewed by Registered Nurse (Print): ____________ Signature: ____________ Date: ________

RN approval for self-carry/self- administration of emergency medication: ____________ Date: ________

Order Review (Print) ____________ Date: ________ Order Review (Print) ____________ Date: ________

Asthma Medication Administration School Authorization Form

ASTHMA ACTION PLAN for School Year 2020-2021 (including summer school) School#: 301 Grade: ______

Student Name: ______________ Birth Date: ________ **Peak Flow Personal Best:** ________

Parent/Guardian's Name: ______________ Home #: ________ Work #: ________ Cell #: ________

ASTHMA SEVERITY: ☐ Exercise Induced ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

CHECK SYMPTOMS/INDICATIONS FOR MEDICATION USE

GREEN ZONE

CONTROLLER MEDICATIONS – TO BE USED DAILY AT HOME UNLESS OTHERWISE INDICATED

- ☐ Breathing is good
- ☐ No cough or wheeze
- ☐ Can work, exercise, play
- ☐ Other: ________
- ☐ Peak flow greater than ______ (80% personal best)

Medication	Dose	Route	Frequency/Time
			☐ School
			☐ School
			☐ School

EXERCISE ZONE

☐ **Prior to exercise/sports/physical education (PE)**

Medication (Rescue Medication)	Dose	Route	Frequency/Time
		Inhaled ☐ w/spacer	

If using more than twice per week for exercise/ sports/PE notify healthcare provider and parent/guardian

YELLOW ZONE

RESCUE MEDICATIONS – TO BE ADDED TO GREEN ZONE MEDICATIONS FOR SYMPTOMS

- ☐ Cough or cold symptoms
- ☐ Wheezing
- ☐ Tight chest or shortness of breath
- ☐ Cough at night
- ☐ Other: ________
- ☐ Peak flow between ______ and ______ (50% - 79% personal best)

Medication	Dose	Route	Frequency/Time
		Inhaled ☐ w/spacer	PRN
		Inhaled ☐ w/spacer	PRN

If symptoms do not improve in ________ minutes, notify healthcare provider and parent/guardian.
If using more than twice per week, notify healthcare provider and parent/guardian.

RED ZONE

EMERGENCY MEDICATIONS – TAKE THESE MEDICATIONS AND CALL 911

- ☐ Medication is not helping within 15-20 minutes
- ☐ Breathing is hard and fast
- ☐ Nasal flaring or intercostal retractions
- ☐ Lips or fingernails blue
- ☐ Trouble walking or talking
- ☐ Other: ________
- ☐ Peak flow ~~greater~~ less than ______ (50% personal best)

Medication	Dose	Route	Frequency/Time
		Inhaled ☐ w/spacer	
		Inhaled ☐ w/spacer	

CONTACT THE PARENT/GUARDIAN AFTER CALLING 911

Triggers

- ☐ Chalk dust
- ☐ Cigarette smoke
- ☐ Colds/Flu
- ☐ Dust/Dust mites
- ☐ Stuffed animals
- ☐ Carpet
- ☐ Exercise
- ☐ Mold
- ☐ Ozone alert days
- ☐ Pests
- ☐ Pets
- ☐ Plants
- ☐ Flowers
- ☐ Cut grass
- ☐ Pollen
- ☐ Strong odors
- ☐ Perfume
- ☐ Cleaning products
- ☐ Sudden change in temperature
- ☐ Wood smoke
- ☐ Foods
- ☐ Other ________

HEALTHCARE PROVIDER AUTHORIZATION

I authorize the administration of the medications as ordered above.

Student may self-carry medications: ☐ Yes ☐ No

Healthcare Provider Name: ______________

Signature: ______________

Office #: ______________

Date: ______________

(Healthcare Provider's Office Stamp)

PARENT/GUARDIAN AUTHORIZATION

I authorize the administration of the medications as ordered above.

I acknowledge that my child: ☐ is ☐ is not authorized to self-carry his/her medication(s).

Signature: ______________

Date: ______________

RECEIVED IN HEALTH SUITE BY ______________ DATE ______

REVIEWED BY REGISTERED NURSE

Name (Print): ______________

Signature: ______________

Date: ______________

Authorized to self-carry medications: ☐ Yes ☐ No

Order Review

(Print) ______________ Date: ______

(Print) ______________ Date: ______

Baltimore City Health Department **Baltimore City Public Schools**

SEIZURE ACTION PLAN

Student Name:________________________ **Birth Date:** ____________ **School Year:** 2020-2021 including the summer session

School #: 301 **Grade:** _______ **Condition for which Medication/Treatment is being administered:** ________________________

Seizure Type (Please mark which type):

Generalized			Partial
☐ Grand Mal	☐ Absence	☐ Myoclonic	☐ Simple (circle which type): Motor Sensory Psychological
☐ Clonic	☐ Tonic	☐ Atonic	☐ Complex
			☐ Partial with secondary generalization

Does this student have a Vagus Nerve Stimulator? ☐ **Yes** ☐ **No**

PLEASE NOTE: A full time nurse will be present in school to administer diazepam gel during school hours, as prescribed.

HEALTHCARE PROVIDER'S AUTHORIZATION

☐ **Maintenance/Daily Medication (to be given during school hours)**

Medication Name:________________________ **Strength:**__________ **Dose:** __________ **Route:**________

Time(s) in School:__________________________

Relevant side effects: □ **None expected** □**Specify:**____

☐ **Emergency Medication (to be given during school hours): DIAZEPAM RECTAL GEL**

Medication Name: Diazepam rectal gel **Strength:** 5 mg/mL **Dose:** ________________mg **Route:** Rectally

Times in School: PRN **Frequency:** __________________________

For what symptoms: Seizure activity > __________ minutes OR for ____________ or more seizures in _________ hours

Relevant side effects: □ None expected □ Specify: headache; blurred vision; dizziness; drowsiness; tiredness; sleep problems (insomnia); slurred speech; loss of balance or coordination; nausea; vomiting; stomach pain; diarrhea;

Other: ____

☐ **Emergency Medication (to be given during school hours): OTHER (if applicable)**

Medication Name:________________________**Strength:**________ **Dose:** __________ **Route:**________

Time(s) in School: PRN **Frequency:**________________

For what symptoms: Seizure activity > __________ minutes OR for ____________ or more seizures in _________ hours

Relevant side effects: □ **None expected** □**Specify:**____

☐ **Emergency Treatment: VAGUS NERVE STIMULATOR (if applicable)**

Location of VNS:__________________________________

For what symptoms: Seizure activity > __________ minutes OR for ____________ or more seizures in _________ hours

Repeat Swipe if:____

Max number of times to swipe:________________

It is the Bureau of School Health's policy for 911 to be called for seizures lasting longer than 5 minutes, unless otherwise specified by the healthcare provider.

□ **Other(please specify):** ____

____

Healthcare Provider's Name/Title: ________________________ (Type or print) Office #: ______________ FAX #: ______________ Healthcare Provider's Signature: ________________________ (Original signature or signature stamp ONLY)	(Healthcare Provider's Office Stamp)

PARENT/GUARDIAN AUTHORIZATION

I understand that designated school health services staff or their designee will administer the medication as prescribed by the above healthcare provider. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I acknowledge that the Registered Nurse (RN) can communicate with the healthcare provider as allowed by HIPAA. I authorize the RN to share this information with school staff that have a legitimate educational interest in my child.

Parent/Guardian Signature: ________________________ **Date:** _________ **Emergency Phone #:** ______________

Date received in health suite:__________________ **by** ______________________________

Reviewed by Registered Nurse (Print): ____________________ **Signature:**____________________**Date:**________

Order Review (Print)____________________**Date**__________ **Order Review (Print)**____________________**Date**__________

BALTIMORE CITY HEALTH DEPARTMENT BALTIMORE CITY PUBLIC SCHOOLS

SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for the (current) school year 2020-2021 ____________, including the summer session.

This form must be entirely completed in order for school health services staff or their designee 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 a pharmacist or healthcare provider.
- Non-prescription medication must be in the original unopened/sealed container with the label intact.
- An adult must bring in the medication to the school.
- The registered nurse (RN) will call the healthcare provider, as allowed by HIPAA, if a question arises about the student and/or the student's medication.
- **Expired and discontinued medication not picked up by the last day of school will be destroyed.**

HEALTHCARE PROVIDER'S AUTHORIZATION

Student Name: ______________________ Birth Date: ______________ Grade: ________ School #: 301

Condition for which medication is being administered: ______________________

Medication Name: ______________________ Strength: ______________

Dose: ______________ Route: ______________ ☐ Time(s) In School: ______________

☐ PRN & Frequency: ______________ for what symptoms? ______________

Relevant side effects: ☐ None expected ☐ Specify: ______________________

Medication shall be administered from: ______________ to ______________

Month/Day/Year Month/Day/Year

Healthcare Provider's Name/Title: ______________________

(Type or print)

Office #: ______________ FAX #: ______________

Address: ______________________

____

Healthcare Provider's Signature: ______________ **Date:** ________

(Original signature or signature stamp ONLY)

(Healthcare Provider's Office Stamp)

Discontinue Medication (HCP Signature): ______________________ **Date:** ______________

PARENT/GUARDIAN AUTHORIZATION

I understand that designated school health services staff or their designee will administer the medication as prescribed by the above healthcare provider. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I acknowledge that the Registered Nurse (RN) can communicate with the healthcare provider as allowed by HIPAA. I authorize the RN to share this information with school staff that have a legitimate educational interest in my child.

Parent / Guardian Signature: ______________________ **Date:** ______________

Home Phone #: ______________ **Cell #:** ______________ **Work #:** ______________

FOR ALTERED SCHOOL SCHEDULES, THE FOLLOWING MEDICATION GUIDELINE WILL APPLY UNLESS OTHERWISE INDICATED IN WRITING:

- Medication can be administered one hour before and one hour after the prescribed time of administration

SELF CARRY/ SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of **emergency** medication may be authorized by the healthcare provider and must be approved by the registered nurse according to the School Medication Administration Policy.

Healthcare Provider's authorization for self-carry/self-administration of emergency medication: ______________

Signature Date

Registered Nurse approval for self-carry/self-administration of emergency medication: ______________

Signature Date

Date received in health suite: ______________ by: ______________

Order reviewed by Registered Nurse (Print): ______________ Signature: ______________ Date: ________

Order Review (Print)______________ Date: ________ Order Review (Print)______________ Date: ________

Order Review (Print)______________ Date: ________ Order Review (Print)______________ Date: ________

BALTIMORE
CITY HEALTH
DEPARTMENT

Bureau of School Health **Medication Policy**

School Year 2020-2021

Administration of medication in the school setting is the responsibility of the school health staff. The Registered Nurse (RN) must review and sign all orders before medication can be administered by the School Health Aide. The RN will only share information with school staff that have a legitimate educational interest in the student.

1. All medication order forms must be completed by a healthcare provider and signed by a parent/guardian *each* school year. Forms may be obtained from the school health staff or the web site: www.baltimorehealth.org/schoolhealth.html.
2. The school health staff cannot and will not administer any medication without a completed medication order form.
3. Routine/scheduled medications will not be administered intermittently (i.e.: Adderall, Focalin XR, Ritalin, Vyvanse, etc.).
4. Medication can be administered one hour before or one hour after the prescribed time of administration.
5. The first dose of any new medication cannot be given in school unless required for emergency treatment. (Exceptions include: Epinephrine Auto-Injector [ex. EpiPen®], Albuterol Metered Dose Inhaler, Glucagon, Diastat® or any other medication required for emergency treatment).
6. The medication must be delivered to the Health Suite by a parent/guardian or responsible adult. School Health Staff will not accept any medication without the completed medication order form.
7. The prescription medication must be labeled by the pharmacy with the student's name, provider's name, medication name, dose, route of administration, time of administration and expiration date. All metered dose inhalers must be in a pharmacy labeled box when brought to the Health Suite.
8. Over-the-counter medication must be brought in the original unopened package. *It does not have to be pharmacy labeled*.
9. A separate form must be completed for each medication prescribed. A new form is required for any time or dose changes.
10. Discontinued medication will be held for one week after request for pick up. All remaining medication beyond that date will be discarded or destroyed.
11. Any student found with medication in school, without an order from a healthcare provider, will have their medication taken and held in the health suite. The parent/guardian will be notified and requested to pick up the medication. *Medication remaining after one week will be discarded or destroyed.*
12. Medications/supplies will be stored in the health suite. Certain medications (ex. Metered Dose Inhaler, EpiPen®) may be self-carried if the healthcare provider authorizes the student to self-administer and the RN determines that the student is responsible and capable of self-administering the medication. Permission may be denied or revoked, if in the RN's judgment, it is unsafe for the student to carry the medication.
13. Medication during a field trip: parent/guardian is recommended to notify the school health staff one week before the scheduled trip. The RN will explore options and make plans for medication administration on the day of the trip.
14. Medication will be discarded or destroyed if not picked up by the last day of school or when it expires.

I confirm that I have received and understand the Baltimore City Health Department School Medication Administration Policy

Parent/Guardian Signature: ______________________ Date: ____________

Print Student Name: ______________________ School #: 301