

Medication and Immunization Policy

I understand that, if my child requires daily or intermittent medication (prescription or over-the-counter) during school hours, a Baltimore City Health Department "Request to Administer Medication in School" form must be completed and signed by both the parent/guardian and the ordering physician. I understand that a separate form is necessary for every medication my child needs. I understand that no medication, prescription or over-the-counter, can be held or dispensed by the school without a signed physician's order. I understand that students are not authorized to carry an inhaler or Epi-pen unless the student's physician has indicated such on the Medication form. I understand that all medications will be stored in the Health Suite, and that discontinued medication must be picked up by the parent/guardian immediately at the time of discontinuation. I understand that expired and/or discontinued medication remaining in the Health Suite on the last day of school will be safely disposed of.

I understand that a completed current immunization certificate from the Maryland Department of Health and Mental Hygiene must be on file in the school office prior to my child's first day of school. I understand that my child will not be permitted to attend school until which time the completed certificate is on file in the school office.

Parent/Guardian Name: _____ Parent/Guardian Signature _____
print in blue or black ink

BRIEF HEALTH HISTORY

Print child's full name _____ Student DOB _____
first middle last mm/dd/yy

Please circle yes or no below. If you need more space, you may attach additional information to this form.
Please print clearly in dark blue or black ink.

Congenital diseases? yes/no If yes, please explain:

Special physical needs? yes/no If yes, please explain:

Medical conditions? yes/no If yes, please explain:

*Requires medications during school day? yes/no

***If yes, a completed and signed Request to Administer Medication in School form, per medication, is required to be on file in the Health Suite.**

List any allergies your child has, including allergies to foods and medicines:

1. _____ 2. _____ 3. _____ 4. _____

List any medications your child takes on a regular basis.
Include prescription and over-the-counter medications.

You if need to include more information than this form provides, you may use a separate sheet and attach it.

Name of medication	Dosage and Frequency	For what condition?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

OVER PLEASE