Archdiocese of Baltimore Department of Catholic Schools

EMERGENCY CONTACT FORM

K-12

INSTRUCTIONS TO PARENTS:

(1) Complete all items on form. Sign and date where indicated. Please mark "N/A" if an item is not applicable.

(2) Notify the school office in writing within five (5) school days of any change to the information on this form.

(3) If any court order, custody order, or protective order affects who may contact your child or take your child from school, attach a copy to this form and complete the Restrictions on Release section below.

NOTE: THIS FORM MUST BE UPDATED ANNUALLY.

Child's Name:			**Birth date:**	**Sex:** ☐ **M** ☐ **F**
Last	First	Middle	MM/DD/YYYY	
Address:				
Number / Street	Apt#	City	State	Zip

Enrollment Date _____ **Grade** _____ **Primary language in the home** _____

Parent/Legal Guardian Information		
Parent/Guardian Name		
Relationship		
Email		
Home Phone		
Cell Phone		
Work Phone		
Employer		

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

Any person taking a student from school must present government-issued photo identification. The school will not release a student to a person who is not listed on this form without the verified authorization of a parent/guardian.

Authorized Emergency Contact Information			
Authorized Contact Name			
Relationship			
Home Phone			
Cell Phone			
Work Phone			
Address			

RESTRICTIONS ON RELEASE AND CUSTODY ORDERS

Is there any court order, custody order, parenting plan, or protective order that limits who may contact your child, receive information about your child, or take your child from school? ☐ **No** ☐ **Yes** — If Yes, a copy is attached

The school will follow the most recent order on file. It is the parent/guardian's responsibility to provide the school with a copy of any new or amended order.

HEALTH INFORMATION

Child's Physician or Source of Health Care Name: _____

Telephone: _____

Address: _____

Health Insurance Carrier _____ **Policy / Member No**. _____

Known Allergies (food, insect, drug, latex) and EMERGENCY MEDICATION carried or stored at school:

_____

Current Medications and relevant medical conditions responding personnel should know:

_____

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. By signing below, I authorize the responsible person at the school to: (1) summon emergency medical services and have my child transported to the nearest hospital emergency room; (2) disclose to responding emergency medical personnel and to treating providers the health information on this form and in my child's school health record that is necessary for my child's care; and (3) if I cannot be reached, consent on my behalf to examination and emergency treatment of my child by emergency medical personnel and hospital staff. I understand that I am financially responsible for the cost of emergency transport and treatment. I certify that the information on this form is accurate and complete, and I agree to notify the school promptly of any change.

Signature of Parent/Guardian Date

Printed Name of Parent/Guardian Printed Name of Student

Maryland Schools Record of Physical Examination

To Parents or Guardians:

In order for your child to enter a Maryland Public school for the first time, the following are required:

- **A physical examination by a physician or certified nurse practitioner must be completed within nine months prior to entering the public school system or within six months after entering the system.** A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement. https://2019-dsd.maryland.gov/regulations/Pages/13A.05.05.07.aspx
- **Evidence of complete primary immunizations against certain childhood communicable diseases is required for all students in preschool through the twelfth grade.** A Maryland Immunization Certification form for newly enrolling students may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer-generated immunization record form and the required immunizations must be completed before a child may attend school. This form can be found at: https://health.maryland.gov/phpa/OIDEOR/IMMUN/Shared%20Documents/MDH_896_form.pdf.
- **Evidence of blood testing is required for all students who reside in a designated at-risk area when first entering Pre-kindergarten, Kindergarten, and 1st grade**. The Maryland Department of Health Blood Lead Testing Certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at: https://health.maryland.gov/phpa/OEHFP/Documents/MDH%20Blood%20Lead%20Testing%20Certificate%202023.fillable.pdf

Exemptions from a physical examination and immunizations are permitted if they are contrary to a students' or family's religious beliefs. Students may also be exempted from immunization requirements if a physician/nurse practitioner or health department official certifies that there is a medical reason not to receive a vaccine. Exemptions from Blood-Lead testing is permitted if it is contrary to a family's religious beliefs and practices. The Blood- lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

The health information on this form will be available only to those health and education personnel who have a legitimate educational interest in your child.

Please complete Part I of this Physical Examination form. Part II must be completed by a physician or nurse practitioner, or a copy of your child's physical examination must be attached to this form.

If your child requires medication to be administered in school, you must have the physician complete a medication administration form for each medication. This form can be obtained at http://marylandpublicschools.org/about/Documents/DSFSS/SSSP/SHS/medforms/medicationform404.pdf. **If you do not have access to a physician or nurse practitioner or if your child requires a special individualized health procedure, please contact the principal and/or school nurse in your child's school.**

Maryland State Department of Health and Mental Hygiene Maryland State Department of Education

Records Retention - This form must be retained in the school record until the student is age 21.

Part 1 Health Assessment

To be completed by parent or guardian

Student's Name (Last, First, Middle) _____ Birthdate (MM/DD/YY) _____ Gender _____ Grade _____

Name of School _____ Phone _____

Address (Number, Street, City, State, Zip) _____

Parent / Guardian Names _____

Where do you usually take your child for routine medical care? Phone _____

Name _____ Address _____

When was the last time your child had a physical exam? Month _____ Year _____

Where do you usually take your child for dental care? Phone _____

Name _____ Address _____

Assessment of Student Health

To the best of your knowledge, has your child has any problem with the following? Please check and provide comments if yes.

Student Health Issues	Yes	No	Comments
Allergies (Food, Insects, Drugs, Latex)			
Allergies (Seasonal)			
Asthma or Breathing Problems			
Behavior or Emotional Problems			
Birth Defects			
Bleeding Problems			
Cerebral Palsy			
Dental			
Diabetes			
Ear Problems or Deafness			
Eye or Vision Problems			
Head Injury			
Heart Problems			
Hospitalizations (When, Where)			
Lead Poisoning / Exposure			
Learning Problems / Disabilities			
Limits on Physical Activity			
Meningitis			
Prematurity			
Problem with Bladder			
Problem with Bowels			
Problem with Coughing			
Seizures			
Serious Allergic Reactions			
Sickle Cell Disease			
Speech Problems			
Surgery			
Other			

Part 1 Health Assessment - continued

To be completed by parent or guardian

Does your child take any medication?

☐ No ☐ Yes Name(s) of Medications _____

☐ No ☐ Yes Treatment _____, etc.

Does your child require any special procedure(s) (catheterization, etc.)?

☐ No ☐ Yes Specify _____

_____ _____

Parent / Guardian Signature Date

Part II – School Health Assessment

*To be completed **ONLY** by Physician / Nurse Practitioner*

Student's Name (Last, First, Middle) _____ Birthdate (MM/DD/YY) _____ Gender _____ Grade _____

Name of School _____

1. Does the child have a diagnosed medical condition?

☐ No ☐ Yes _____

_____

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan".

☐ No ☐ Yes _____

_____

3. Are there any abnormal findings on evaluation for concern?

☐ No ☐ Yes _____

_____

Evaluation Findings / Concerns

Physical Exam	WNL	ABNL	Area of Concern	Health Area of Concern	Yes	No
Head				Attention Deficit / Hyperactivity		
Eyes				Behavior / Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure / Elevated Lead		
GI				Learning Disabilities / Problems		
GU				Mobility		
Muscoskeletal/ Orthopedic				Nutrition		
Neurological				Physical Illness / Impairment		
Skin				Psychosocial		
Endocrine				Speech / Language		
Psychosocial				Vision		
Other				Other		

4. **RECORD OF IMMUNIZATIONS** – DHMH 896 is required to be completed by a health care provider or a computer-generated immunization record must be provided.

Part II – School Health Assessment - continued

*To be completed **ONLY** by Physician / Nurse Practitioner*

5. Is the child on medication? If yes, indicate medication and diagnosis.

☐ No ☐ Yes _____

_____

(A medication administration form must be completed for medication administration in school).
http://test.msde.maryland.gov/about/Documents/DSFSS/SSSP/SHS/medforms/medicationform404.pdf

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.

☐ No ☐ Yes _____

_____

7. Screenings

Screenings	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	
Hearing		
Vision		

(Child's Name) _____ has had a complete physical examination and has:

No evident problem that may affect learning or full school participation _____

Problems noted above _____

Additional Comments:

_____
_____
_____
_____
_____
_____

_____ _____
Physician / Nurse Practitioner (Type or Print) Phone

_____ _____
Physician / Nurse Practitioner (Signature) Date

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

STUDENT/SELF NAME: _____

LAST FIRST MI

STUDENT/SELF ADDRESS: _____ CITY: _____ ZIP: _____

SEX: MALE ☐ FEMALE ☐ OTHER ☐ BIRTH DATE: _____/_____/_____

COUNTY: _____ SCHOOL: _____ GRADE: _____

FOR MINORS UNDER 18:

PARENT/GUARDIAN NAME: _____ PHONE #: _____

#	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr	
1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #6
2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #2		DOSE #2	DOSE #7
3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	DOSE #3	Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	DOSE #3	DOSE #8
4	DOSE #4	DOSE #4	DOSE #4	DOSE #4	DOSE #4				DOSE #1	DOSE #1	DOSE #1	DOSE #1	DOSE #4	DOSE #9
5	DOSE #5			DOSE #5					DOSE #2	DOSE #2	DOSE #2	DOSE #2	DOSE #5	DOSE #10
									DOSE #3		DOSE #3			

To the best of my knowledge, the vaccines listed above were administered according to the provided information in Maryland's Immunization Information System.

1. _____
   Signature Title Date
   (Medical provider, local/state health department official, school official, or child care provider only)
2. _____
   Signature Title Date
3. _____
   Signature Title Date

Signature lines 2 and 3 are for certification of vaccines given after the initial signature. Otherwise, this form may not be altered.

Clinic / Office Name
Office Address/ Phone Number

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until _____/_____/_____
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, _____

Signed: _____ Date: _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age-appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the **"Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs"** guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

CHILD'S NAME: _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE: _____
MM/DD/YYYY

PARENT/GUARDIAN NAME: _____ PHONE NO.: _____

ADDRESS: _____ CITY: _____ ZIP: _____

Test Date (mm/dd/yyyy)	Type of Test (V = venous, C = capillary)	Result (µg/dL)	Comments

Health care provider or school health professional or designee only: To the best of my knowledge, the blood lead tests listed above were administered as indicated. (Line 2 is for certification of blood lead tests after the initial signature.)

1. _____ _____
Name Title

_____ _____
Signature Date

2. _____ _____
Name Title

_____ _____
Signature Date

Clinic/Office Name, Address, Phone

Health care provider: Complete the section below if the child's parent/guardian refuses to consent to blood lead testing due to the parent/guardian's stated bona fide religious beliefs and practices:

Lead Risk Assessment Questionnaire Screening Questions:

Yes ○ No ○ 1. Does the child live in or regularly visits a house/building built before 1978?
Yes ○ No ○ 2. Has the child ever lived outside the United States or recently arrived from a foreign country?
Yes ○ No ○ 3. Does the child have a sibling or housemate/playmate being followed or treated for lead poisoning?
Yes ○ No ○ 4. Does the child frequently put things in his/her mouth such as toys, jewelry, or keys, or eat non-food items (pica)?
Yes ○ No ○ 5. Does the child have contact with an adult whose job or hobby involves exposure to lead?
Yes ○ No ○ 6. Is the child exposed to products from other countries such as cosmetics, health remedies, spices, or foods?
Yes ○ No ○ 7. Is the child exposed to food stored or served in leaded crystal, pottery or pewter, or made using handmade cookware?

Provider: If any responses are **YES**, I have counseled the parent/guardian on the risks of lead exposure. _____
Provider Initial

Parent/Guardian: I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child and understand the potential impact of not testing for lead exposure as discussed with my child's health care provider.

_____ _____
Parent/Guardian Signature Date

Environmental Health Bureau
mdh.envhealth@maryland.gov

MARYLAND DEPARTMENT OF HEALTH BLOOD LEAD TESTING CERTIFICATE

For a copy of this form in another language, please contact the MDH Environmental Health Helpline at (866) 703-3266.

How To Use This Form

➔ **A health care provider may provide the parent/guardian with a copy of the child's blood lead testing results from ImmuNet as an alternative to completing this form (COMAR 10.11.04.05(B)).**

Maryland requires all children to be tested at the 12 and 24 month well-child visits (at 12-14 and 24-26 months old respectively), and both test results should be included on this form (see COMAR 10.11.04). If the test at the 12-month visit was missed, then the results of the test after 24 months of age is sufficient. A child who was not tested at 12 or 24 months should be tested as early as possible.

A parent/guardian and a child's health care provider should complete this form when enrolling a child in child care, pre-kindergarten, kindergarten, or first grade. Completed forms should be submitted by the parent/guardian to the Administrator of a licensed child care, public pre-kindergarten, kindergarten, or first grade program prior to entry. The child's health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature sections. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

Frequently Asked Questions

1. **Who should be tested for lead?**

   All children in Maryland should be tested for lead poisoning at 12 and 24 months of age.

2. **What is the blood lead reference value, and how is it interpreted?**

   Maryland follows the CDC blood lead reference value, which is 3.5 micrograms per deciliter (µg/dL). However, there is no safe level of lead in children.

3. **If a capillary test (finger prick or heel prick) shows elevated blood lead levels, is a confirmatory test required?**

   Yes, if a capillary test shows a blood lead level of ≥3.5 µg/dL, a confirmatory venous sample (blood from a vein) is needed. The higher the blood lead level is on the initial capillary test, the more urgent it is to get a confirmatory venous sample. See Table 1 (CDC) for the recommended schedule.

4. **What kind of follow-up or case management is required if a child has a blood lead level above the CDC blood lead reference value?**

   Providers should refer to the CDC's Recommended Actions Based on Blood Lead Level (https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm).

5. **What programs or resources are available to families with a child with lead exposure?**

   Maryland and local jurisdictions have programs for families with a child exposed to lead:
   - Maryland Home Visiting Services for Children with Lead Poisoning
   - Maryland Healthy Homes for Healthy Kids – no-cost program to remove lead from homes

   For more information about these and other programs, call the Environmental Health Helpline at (866) 703-3266 or visit: https://health.maryland.gov/phpa/OEHFP/EH/Pages/Lead.aspx.

   Maryland Department of the Environment Center for Childhood Lead Poisoning Prevention:
   https://mde.maryland.gov/programs/LAND/LeadPoisoningPrevention/Pages/index.aspx

   Families can also contact the Mid-Atlantic Center for Children's Health & the Environment Pediatric Environmental Health Specialty Unit – Villanova University, Washington, DC.
   Phone: (610) 519-3478 or Toll Free: (833) 362-2243
   Website: https://www1.villanova.edu/university/nursing/macche.html

ARCHDIOCESE OF BALTIMORE
CATHOLIC SCHOOLS
STANDARD OPERATING PROCEDURE (SOP)
Medication Administration Procedures

School: _____

Related Policy: Administration of Medication in Schools, Maryland State School Health Services Guidelines

Effective Date: July 1, 2026 (School Year 2026–2027)

Prepared By: Office of Risk Management

BACKGROUND AND PURPOSE

This Medication Administration Standard Operating Procedures (SOP) is designed to assist each school with consistent and standardized procedures for the safe receipt, storage, administration, documentation, monitoring, and disposal of medications administered to students during the school day and during school-sponsored activities in accordance with "Administration of Medication in Schools, Maryland State School Health Services Guidelines, September 2025." (See Attachment 1)

The Archdiocese has drawn upon the State guidelines in developing these procedures. This SOP states the Archdiocese's own operating procedures. It does not adopt the State guidelines — which were developed for public local school systems — as the standard of care applicable to Archdiocesan schools. It is the expectation of the Archdiocese that parents/guardians will administer medications at home whenever possible and should collaborate with their child's health care provider to establish medication schedules that minimize administration at school whenever possible, as medically appropriate.

APPLICABILITY AND TERMINOLOGY. This SOP applies to every school of the Archdiocese of Baltimore. As used in this SOP: "school nurse" means a registered nurse licensed in Maryland who is employed by or under contract to the school or the Archdiocese; "school health personnel" means the school nurse together with any certified medication technician (CMT) or other individual trained and delegated by the school nurse; and "Office of Risk Management" means the Archdiocesan Office of Risk Management.

This SOP addresses practices that include the administration of prescription medications, as well as over-the-counter medications. This document includes prompts that permit each school nurse to document school-specific processes within a particular school.

PRESCRIPTION MEDICATION

Each prescription medication may only be made available to the student after receipt of the Maryland State School Medication Administration Authorization Form, ed. 2025 (the "Medication Authorization Form"). (See Attachment 2)

The medication administration/authorization form must meet the following minimum requirements:

- ❑ Be signed by the authorized prescriber or properly stamped with the prescriber's signature (a printed name stamp alone is not acceptable);
- ❑ Be signed by the parent/guardian;

- ❑ A separate medication form is needed for each medication to be administered in school unless there is a specific state order form identified for chronic disease management (such as diabetes or allergies) that allows multiple medications to be ordered on one form;
- ❑ All prescription medication orders must be renewed annually;
- ❑ The medication administration/authorization form is to be filed in the student's school health record per the Maryland Student Records System Manual and retained in accordance with the Records Retention section of this SOP;
- ❑ Faxed/scanned medication orders for the administration of medication may be accepted when submitted on a medication administration/authorization form and signed by an authorized prescriber;
- ❑ Verbal orders from an authorized prescriber should only be taken when necessary and must be taken only by a registered nurse (RN) or a licensed practical nurse (LPN) and co-signed by an RN. A school that does not have a licensed nurse available to receive the order may not accept a verbal order. Verbal orders must also meet the following requirements:
    - o Verbal orders shall be documented by the nurse in the student's health record and must be followed up no later than 72 hours, by having a medication administration/authorization form completed by the prescriber;
    - o If unable to obtain the written order, the nurse shall attempt to contact both the prescriber and parent/guardian;
    - o If the written order is not received within 72 hours, the medication may no longer be administered in school and must be discontinued;
    - o The parent/guardian should sign the form within a locally determined amount of time, not to exceed 72 hours after receipt of the form by the authorized prescriber.

In addition, please see Attachment 3, Medication Administration Record (MAR). This document is to be utilized to record all related actions taken, per individual student, with regard to each medication to be available for administration for the student.

School Specific Notations:

_____

_____

_____

_____

PARENTAL/GUARDIAN CONSENT

Each Medication Authorization Form requires the following:

- ❑ Written parental/guardian consent documented by parental/guardian signature;
- ❑ A separate Maryland Medication Authorization Form for each medication ordered and for each new order; and
- ❑ If the Medication Authorization Form is received directly from the provider, the parent or guardian must come to the school, or other arrangements must be made to have the parent sign the form, within three (3) business days of receipt.

School Specific Notations:

_____

_____

_____

_____

LABELING, STORAGE, AND DISPOSAL

Each medication maintained under this program must meet the following conditions:

- ❑ The medication must be in the original container;
- ❑ Medications must be brought to the school by the parent/guardian or specified responsible adult;
- ❑ The quantity of medication received must be verified by the school nurse or trained designee as soon as the parent/guardian delivers the medication;
- ❑ Labeling for each medication must include the following:
    - Name of student;
    - Student date of birth;
    - Name of medication;
    - Dosage of medication to be given;
    - Strength of medication;
    - Frequency of administration;
    - Route of administration;
    - Name of authorized prescriber ordering medication;
    - Date of prescription;
    - Manufacturer expiration for over the counter (OTC) medications;
    - Pharmacy discard date for prescription medications; and
    - Pharmacy contact information;
- ❑ Where a medication is delivered to the school in an unopened manufacturer's package that does not bear the information listed above, the school nurse or trained designee shall affix a label containing that information upon receipt;
- ❑ All medication must be stored in a locked cabinet;
- ❑ Medication that requires refrigeration must be stored in a locked box/locked refrigerator;
- ❑ The refrigerator temperature is to be checked daily and logged appropriately;
- ❑ If the refrigerator fails, the nurse shall immediately move the products to a stable backup unit maintaining 2°C to 8°C (36°F to 46°F), label them "DO NOT USE," and contact the Maryland Department of Health or the product manufacturer. Medications may not be discarded until viability has been assessed.
- ❑ Access to the locked medication shall be under the authority of the school health professional, the principal, and/or the principal's designee;
- ❑ For drugs or devices dispensed in the manufacturer's original packaging, the expiration date shall be the expiration date set by the manufacturer;
- ❑ For drugs or devices dispensed in a container other than the manufacturer's original packaging, the expiration date shall be the lesser of:
    - One year from the date of dispensing; or

- The month and year when the drugs or devices expire.

❑ If a pharmacy labels a medication with an expiration date shorter than what is required by Md. Code Ann., Health Occ. §12-505 and/or described above, consult with the pharmacist to understand the clinical rationale behind this decision;

❑ All medication must be removed from school premises upon appropriate notification (to/from the parent/guardian/authorized prescriber/school nurse) of the medication being discontinued, expired, or at the end of the school year;

❑ School nurses must plan for the return of medication to parents/guardians during unplanned extended school closures;

❑ If not retrieved by a parent/guardian or specified responsible adult, unused and unclaimed medication should be disposed of appropriately;

❑ Medication that is not retrieved within ten (10) school days after written notice to the parent/guardian shall be disposed of under this SOP, and the disposal shall be documented and witnessed;

❑ Based on nursing practice standards, opioids and controlled substances should be witnessed during disposal;

❑ Empty asthma inhalers may be disposed of in the trash;

❑ Sharps (needles and lancets) must be disposed of in a puncture proof container;

❑ Disposal of this container and other medical waste must follow Occupational Safety and Health Administration/Maryland Occupational Safety and Health, and Bloodborne Pathogens Standard.

School Specific Notations:

1. Note Storage and Security Protocol to include location and access.
2. Note Details of Refrigeration and Temperature Monitoring Process.
3. Note Details of Medical Waste Disposal.

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ADMINISTRATION OF MEDICATION

As part of each school's medication administration program, the following must be addressed:

❑ School staff and parents/guardians shall be informed of the medication administration policies and procedures;

❑ Before administration of medications confirm the five rights of medication administration: right patient, right drug, right route, right time, and right dose;

❑ The parent/guardian should give the first dose of any new prescription or over-the-counter medication, except for as needed emergency medications (e.g., epinephrine, glucagon); and

❑ The record of each administration shall be maintained and include student's name, date and time of administration, dosage, route and signature of person administering the medication. The record shall be made on the Medication Administration Record (Attachment 3).

School Specific Notations:

EMERGENCY MEDICATION ADMINISTRATION AND SELF-CARRY

For the proper distribution and use of emergency medications, each school must address the following considerations related to emergency medication administration and self-carry:

- ❑ Students who may require administration of emergency medications in the school setting must have a plan to ensure immediate access to emergency medications;
- ❑ The plan must include the training of school staff to administer medication under authorized parameters;
- ❑ School shall work with parents/guardians to ensure there is sufficient supply of emergency medication provided for students with known life-threatening conditions;
- ❑ In the event of a medical emergency, any school employee who has been trained and delegated by the school nurse in accordance with COMAR 10.27.11 may administer an emergency medication to a student.

For self-carry/self-administration the following conditions must be met:

- ❑ An authorized prescriber must provide a written order for self-carry and/or self-administration of medication;
- ❑ There must be written approval of the parent/guardian;
- ❑ The school nurse must assess and approve the student's ability to self-carry and/or self-administer medication;
- ❑ A plan shall be developed by the authorized prescriber, parent/guardian, and school nurse for students who self-carry and/or self-administer their medications. The plan shall address the following considerations:
    - The need to have ready access to emergency medication;
    - The developmental ability of the student;
    - The safe carrying of medication; and
    - A process of recording the medication administration.

School Specific Notations:

1. Generate a roster of students with emergency medication orders. See Attachment 4, Roster of Emergency Medication Orders.

STOCK EMERGENCY MEDICATION (EPINEPHRINE, ALBUTEROL, AND NALOXONE)

This section states the position of the Archdiocese on emergency medication maintained by the school for use by any student, as distinct from medication supplied for a named student.

- ❑ Each school shall determine, in consultation with the school nurse and the Office of Risk Management, whether it will maintain a supply of stock epinephrine, stock albuterol, and/or naloxone, and shall record that determination below.
- ❑ Where a school maintains stock emergency medication, it shall do so under the standing order of an authorized prescriber, shall store and label the medication in accordance with the Labeling, Storage, and Disposal section of this SOP, and shall monitor expiration dates monthly.
- ❑ Only the school nurse or an employee trained and delegated by the school nurse may administer stock emergency medication. Training shall be documented and refreshed annually.
- ❑ Any administration of stock emergency medication shall be documented on the Medication Administration Record, reported to the parent/guardian the same day, and reported to the Office of Risk Management within one (1) business day.
- ❑ Emergency medical services shall be summoned upon any administration of stock epinephrine or naloxone.

School Specific Notations:

1. Note whether the school maintains stock epinephrine, albuterol, and/or naloxone, the storage location, and the names of trained staff.

OPIOIDS AND OTHER CONTROLLED SUBSTANCES

Due to the addictive nature of and potential abuse of opioids and other controlled substances, schools shall refrain from administering opioids unless absolutely necessary. If an opioid must be administered in school, the guidelines for prescription medications should be followed with the following modifications:

- ❑ The designated school health services staff shall immediately count and record the amount of medication received while witnessed by the parent/guardian or adult delivering the medication;
- ❑ The designated school health services staff shall count opioids and other controlled substances on a scheduled basis while witnessed by a responsible employee. This count should be reconciled with the prior count and medication administration record;
- ❑ The designated school health services staff shall maintain no more than a 30-day supply of opioids and other controlled substances for an individual student;
- ❑ The authorized prescriber and parent/guardian shall provide a new opioid order and authorization every 30 days EXCEPT if the opioid is to be given as needed; and
- ❑ The school nurse should contact the parent/guardian and prescriber to confirm the continued need for the opioid if the medication is to be given PRN for more than 30 days.

School Specific Notations:

OVER-THE-COUNTER (OTC) MEDICATIONS

Administration of OTC medication must be conducted in accordance with the guidelines for prescription medications (outlined above). In addition, all OTC medication must meet the following requirements:

- ❑ Each over-the-counter medication must be accompanied by a completed Consent For Administration of Over-the-Counter Medications. See Attachment 5.
- ❑ Be brought to school in an original, unopened container, and
- ❑ Meet the requirements set forth in the Labeling, Storage, and Disposal section, including having the requirement that the school nurse or trained designee affix the requisite label upon receipt.

A school may not obtain a standing medical order or other medical direction that would permit the school to supply OTC medications to students from a school-held supply. All OTC medication must be provided by the parent or guardian and must meet all of the requirements of administration applicable to prescription medication.

Maryland law does not provide a specific legal definition of over-the-counter medications. For purposes of this SOP, over-the-counter medications are to be considered any medication, therapeutic product, or preparation that may be purchased without a prescription and is intended to prevent, diagnose, treat, relieve, or manage a medical condition, symptom, or health-related complaint. OTC medications include, but are not limited to, oral medications, topical preparations, creams, ointments, gels, lotions, sprays, drops, rinses, lozenges, and similar products.

School Specific Notations:

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ALTERNATIVE AND COMPLEMENTARY THERAPEUTIC PRODUCTS

Alternative and complementary therapeutic products should be administered in accordance with the guidelines for prescription drugs. Examples of alternative and complementary therapeutic products can include, but are not limited to any of the following: herbs and botanicals, homeopathic remedies, nutritional supplements and salves and external applications. Medical cannabis is not an alternative or complementary therapeutic product and is governed by the section that follows.

School Specific Notations:

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MEDICAL CANNABIS

Medical cannabis is not administered, stored, or handled by school personnel, and may not be maintained on school property or at a school-sponsored activity by any employee of the school.

School Specific Notations:

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DELEGATION OF MEDICATION ADMINISTRATION TO AN UNLICENSED INDIVIDUAL

The school nurse shall collaborate with the school administrator to develop plans for the administration of medication in the unexpected absence of the nurse and/or CMT. COMAR 10.27.11.05G and COMAR 10.39.04.09 require that persons routinely administering medication under the direction of a registered nurse be appropriately trained and supervised. The School Health Medication Administration Training Program: Certified Medication Technician (CMT program) is the approved program for school health services program staff. Records of the date and nature of the initial training and every two-year re-certification must be maintained via the Maryland Board of Nursing (MBON). The RN Case Manager/Delegating Nurse (RN CM/DN) will maintain documentation of the required 45-day delegation assessment per the MBON approved curriculum for school health services and according to this SOP.

In all cases, the person to whom the administration of medication is delegated (routinely or unexpectedly), should meet the following criteria set forth in COMAR 10.27.11 and COMAR 10.39.04:

> In the judgement of the nurse, the task can be properly and safely performed by the unlicensed individual without jeopardizing the client's welfare; and that person is competent to perform the task assigned.

Additionally, the person should:

- Be an employee of the school or the Archdiocese;
- Agree to this responsibility;
- Have good attendance;
- Be familiar with the students in the school;
- Possess good organizational skills; and
- Handle stress in a calm manner.

Medication administration is not an appropriate assignment for an unlicensed school/parent volunteer.

School Specific Notations:

1. Provide the names, titles and certification date for each medication technician.

SCHOOLS WITHOUT FULL-TIME NURSING COVERAGE

Several provisions of this SOP assign functions that only a registered nurse may perform, including assessment and approval of self-carry, receipt of verbal orders, delegation to unlicensed personnel, and the packaging of doses for school-sponsored activities. Each school shall therefore record the following:

- ❑ The name, license number, and contact information of the registered nurse of record who serves as the delegating nurse for the school, and the days and hours of on-site nursing coverage;
- ❑ The means by which the delegating nurse may be reached when not on site, and the expected response time;

- ❑ The procedure to be followed when a nursing function required by this SOP arises and no nurse is available, including that no medication requiring nursing judgment may be administered until the delegating nurse has been reached; and
- ❑ Confirmation that the school does not accept verbal orders and does not approve self-carry during periods without nursing coverage.

A school that cannot identify a registered nurse of record shall notify the Office of Risk Management before accepting any medication for administration.

School Specific Notations:

1. Record the delegating nurse of record, coverage schedule, and after-hours contact procedure.

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ADMINISTRATION OF MEDICATION DURING SCHOOL-SPONSORED ACTIVITIES

Routine medications should be administered to students participating in school-sponsored activities following these guidelines:

- ❑ Administer only when absolutely necessary;
- ❑ If feasible timing of doses should be adjusted (in consultation with the authorized prescriber) to occur outside of the timeframe of the school-sponsored activity;
- ❑ Medications to be administered during school-sponsored activities must have been previously administered (i.e., not the first dose);
- ❑ The parent/guardian authorization form and authorized prescriber order must be on file;
- ❑ The one exception is administration of the previously noted rescue medications;
- ❑ Determination of whether a medication is administered during a school-sponsored activity and by whom, shall be determined by the RN school nurse;
- ❑ Alternatives to enable the administration of medications during such activities may include the following:
    - o The parent/guardian may accompany the student and administer the medication;
    - o A single dose of the medication may be placed in a properly labeled envelope or container by the licensed registered school nurse and stored in a locked cabinet in the school health suite to be administered at the school-sponsored activity by selected school personnel;
- ❑ At the conclusion of the activity, the labeled container should be returned to the health suite;
- ❑ A notation shall be made on the student's medication record that the medication was administered. Medication administered by a parent/guardian during a school-sponsored activity must be reported to the school nurse, who shall record it in the student's health record.

School Specific Notations:

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VARIANCE IN ADMINISTRATION OF MEDICATION

Each school shall ensure accurate documentation of any medication variance. If a variance in medication administration occurs (such as missing a dose, giving the incorrect dose, giving a dose at the wrong time, giving an incorrect medication to the student, or giving a student another student's medication), the following procedures should be followed:

- Observe the student for side effects;
- Contact poison control as appropriate;
- Take appropriate action based on nursing judgement and/or authorized prescriber order;
- Notify the parent, school administrator, nursing supervisor and student's health care provider as needed;
- Complete the appropriate reporting forms required by this SOP and notify the Office of Risk Management; and
- Document the occurrence and the action taken.

Any medication errors must be documented using the Medication Error Incident Report. (See Attachment 6).

STOLEN OR LOST MEDICATION

If any medication is reported missing, the school administrator and the Office of Risk Management shall be notified. If the incident involves controlled, dangerous substances, notification of the police is required. Parents shall also be informed in order to replace the medication. Appropriate documentation shall be completed and kept on file and provided to the Office of Risk Management.

School Specific Notations:

EDUCATION ON THE USE OF MEDICATION

As required, the school nurse shall assess and provide health education for students regarding their prescribed medications.

School Specific Notations:

COMMUNICATION WITH AUTHORIZED PRESCRIBER REGARDING THE TREATMENT OF A STUDENT

The school nurse may communicate with an authorized prescriber for concerns or clarification of the medical orders or to share information relevant to the treatment regimen consistent with the parent/guardian authorization obtained on the Health Inventory and on the Medication Authorization

Form. Where no authorization is on file, the school nurse shall obtain the parent/guardian's authorization before communicating with the prescriber, except where disclosure is necessary to address an emergency threatening the health or safety of the student.

In all other respects, the school nurse shall handle student health information in accordance with applicable federal and State privacy law, including the Maryland Confidentiality of Medical Records Act, Md. Code Ann., Health-Gen. §§ 4-301 et seq., and with Archdiocesan policy. Student health information shall be disclosed only to school personnel with a legitimate need to know, to emergency medical personnel in an emergency, and otherwise only as authorized in writing by the parent/guardian or as required by law.

School Specific Notations:

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RECORDS RETENTION

Medication administration/authorization forms, Medication Administration Records, medication error incident reports, verbal order documentation, controlled substance counts, refrigerator temperature logs, and disposal records are part of the student's school health record or the school's health services records, as applicable.

- ❑ Records that form part of the student's school health record shall be retained until the student reaches age twenty-five (25), consistent with Maryland law regarding retention requirements for medical records.
- ❑ Records that do not identify a student, such as refrigerator temperature logs, shall be retained for three (3) years.
- ❑ Records shall be stored securely and disposed of in a manner that protects confidentiality, in accordance with applicable state and federal law.

TRAINING, ANNUAL REVIEW, AND SCHOOL ADOPTION

- ❑ The school nurse shall provide, and document, training for each employee who may be called upon to administer medication. Training shall be completed before the employee administers any medication and refreshed at least annually.
- ❑ Each school shall complete the School Specific Notations throughout this SOP and shall maintain the completed SOP in the school office and the health suite.
- ❑ This SOP shall be reviewed at least annually by the Office of Risk Management and updated as required by changes in law or State guidance.
- ❑ Each school shall record its adoption of the completed SOP below.

Adopted for _____(school) for school year _____

Principal _____ Date _____

School Nurse _____ Date _____

ATTACHMENTS

To avoid confusion with the appendix lettering used in the Archdiocesan forms packet, the documents accompanying this SOP are numbered rather than lettered:

- ❑ Attachment 1 – Administration of Medication in Schools, Maryland State School Health Services Guidelines (September 2025)
- ❑ Attachment 2 – Maryland State School Medication Administration Authorization Form, ed. 2025
- ❑ Attachment 3 – Medication Administration Record (MAR)
- ❑ Attachment 4 – Roster of Emergency Medication Orders
- ❑ Attachment 5 – Consent for Administration of Over-the-Counter Medications
- ❑ Attachment 6 – Medication Error Incident Report

Archdiocese of Baltimore
Department of Catholic Schools

HEALTH INVENTORY

INSTRUCTIONS

In order to ensure adequate information on your child's medical history, an annual health inventory is requested. Having this information better enables the school and our staff to tend to your child's unique and specific medical history and needs. Please complete this form to the best of your ability and return to the school nurse by no later than _____.

This Health Inventory is the annual update to your child's school health record. It does not replace the Maryland Schools Record of Physical Examination, which documents the physical examination required on entry. Where this Inventory and an earlier form differ, the most recently dated form controls. Please answer every item; mark "N/A" if an item does not apply.

PART I – HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name:			**Birth date:**	**Sex:** ☐ **M** ☐ **F**
Last	First	Middle	MM/DD/YYYY	
Address:				
Number / Street	Apt#	City	State	Zip

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		W:	C:	H:
		W:	C:	H:

Medical Care Provider	Health Care Specialist	Dental Care Provider	Health Insurance	Last Time Child Seen for (MM/DD/YYYY)
Name:	Name:	Name:	☐ Yes ☐ No	Physical Exam:
Address:	Address:	Address:		Dental Care:
Phone:	Phone:	Phone:		Specialist

ASSESSMENT OF CHILD'S HEALTH – To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.			
	Yes	**No**	**Comments (required for any Yes answer)**
Allergies (Food, Insect, Drug, Latex)	☐	☐	
Allergies (Seasonal / Environmental)	☐	☐	
Asthma or Breathing	☐	☐	
ADHD	☐	☐	
Autism Spectrum Disorder	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	

	Yes	No	Comments (required for any Yes answer)
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes Mellitus	☐	☐	
Ears or Deafness	☐	☐	
Eyes	☐	☐	
Feeding/Special Dietary Needs	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where, Why)	☐	☐	
Lead Poisoning/Exposure	☐	☐	
Life Threatening/Anaphylactic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sensory Impairment	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Vision	☐	☐	
Other	☐	☐	
Individualized Health Plan, Emergency Action Plan, Asthma or Anaphylaxis Action Plan, or accommodation plan in place	☐	☐	
Condition that may require EMERGENCY ACTION during the school day	☐	☐	

Does your child take medication (prescription or non-prescription) at any time and/or for an ongoing health condition?

☐ **Yes** ☐ **No** — If yes, a completed Maryland State School Medication Administration Authorization Form must be on file before any medication may be given at school. A separate form is required for each medication and must be renewed annually.

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy/Counseling, etc.) ☐ **Yes** ☐ **No** — If yes, attach the Maryland State School Medication Administration Authorization Form and an Individualized Treatment Plan.

Does your child require any special procedures? (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.) ☐ **Yes** ☐ **No** — If yes, attach the Maryland State School Medication Administration Authorization Form and an Individualized Treatment Plan.

AUTHORIZATION TO EXCHANGE HEALTH INFORMATION

I authorize the school nurse or other designated school health personnel to exchange with my child's health care provider(s) named above, and with any provider who issues an order for care at school, the information reasonably necessary to clarify orders, to administer medication or treatment safely, and to develop and carry out a health or emergency action plan for my child. This authorization remains in effect for the current school year unless I revoke it in writing.

Signature of Parent/Guardian _____ Date _____

I UNDERSTAND THIS INFORMATION IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS.

I UNDERSTAND THIS FORM IS MAINTAINED IN MY CHILD'S SCHOOL HEALTH RECORD. IT IS MADE AVAILABLE ONLY TO SCHOOL HEALTH AND EDUCATION PERSONNEL WHO HAVE A LEGITIMATE NEED TO KNOW IN ORDER TO MEET MY CHILD'S HEALTH AND EDUCATIONAL NEEDS, AND TO EMERGENCY MEDICAL PERSONNEL IN AN EMERGENCY.

I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

I AGREE TO NOTIFY THE SCHOOL PROMPTLY OF ANY CHANGE IN MY CHILD'S HEALTH STATUS, MEDICATION, OR TREATMENT DURING THE SCHOOL YEAR.

Signature of Parent/Guardian Date

Printed Name of Parent/Guardian Printed Name of Student