PARENT AUTHORIZATION FOR
OVER-THE-COUNTER MEDICATIONS
OR
SHORT TERM PRESCRIPTION MEDICATION
(Please complete every item on this form)

Student's Name____Student No.___________
Date of
Birth_________________________________School____________________________________

Name of medication_________________________________Dosage______________________

Time of administration____

This student is expected to be receiving this medication for ______________________________
(How long?)

Special instructions regarding this medication____

____

Will this student be carrying and taking this medication on his/her own? _____Yes _____No
Students are not allowed to carry controlled substances (for example, Tylenol #3) and will be required to come to the Health Room to take any medication classed as a controlled substance.

If NO is selected. I/We understand that our child____________________will be assisted to self administer the short term prescription or over-the-counter medication by designated school personnel and the parent will be notified each time the dose is taken by the child and of the circumstances regarding the dose being taken.

If YES is selected. I/We understand that our child _______________________will be responsible for carrying and taking his/her own medication (if we have selected this option), and that he/she is only authorized to carry one day's worth of medication in the ORIGINAL LABELED container that indicates the name of the medication, and the dose of the medication or dosing recommendations.

I/We understand that if our child________________________needs to take a non-prescription over-the-counter medication for more than 5 consecutive school days we will be asked to get a written physician/provider authorization before any more of the medication will be given.

Parent/Guardian Signature____

Printed Name____

Date________________________ Phone no(s)______________________________________

Medication brought by student for storage in the Health Room ______________________
Date

Amount of medication _______________(two adults count pills and record amount)

____ ____________________________________
Signature of person counting **Signature of person counting**

Albuquerque Public Schools
Nursing Services

Individual Medication Log

School Year 2005/2006

Student________________________________ Medication _________________________________
Student number__________ DOB__________ Dosage/Route_______________________________
Teacher______________________Room_____ Time_______________________________________
Nurse's Signature:____

Month	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F
July																									
Time																									
Initials																									
Aug																									
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Sep																									
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Staff Signature:_______________________Initials:____ Staff Signature:_______________________Initials:____
Staff Signature:_______________________Initials:____ Staff Signature:_______________________Initials:____
Staff Signature:_______________________Initials:____ Staff Signature:_______________________Initials:____

Instructions:
1. Enter time medication given & initials of staff supervising in each square.
2. Verify that initials of staff supervising are identified at above.