Albuquerque Public Schools
Nursing Services

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.

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**