ALBUQUERQUE PUBLIC SCHOOLS
PROVIDER ORDER AND MEDICATION AUTHORIZATION FORM

(Please complete every item on this form)

Student's Name: _____

Date of Birth: _____ School: _____

PROVIDER'S ORDER AND STUDENT COMPETENCY STATEMENT

1. I have examined this student for (diagnosis): _____ and have determined she/he requires medication during school hours. ICD-9 code(s): _____ [*required for Medicaid purposes*]

2. Name of medication: _____ Dosage: _____ Route: _____
   Generic substitution is permitted _____YES_____NO

3. Time of administration: _____

4. This student is expected to be receiving this medication (how long?): _____

5. Special instructions regarding this medication (include any periodic screening you would like done and when/how often):
   _____
   _____

6. Contact me if the following signs or symptoms appear: _____
   _____

I believe this student is able to carry and administer her/his own medication (excluding controlled substances) at the appropriate time and in the appropriate way. Please check: _____YES_____NO

Healthcare Provider's Signature: _____Printed Name: _____

Date: _____Phone: _____Fax: _____Email: _____

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PARENT/GUARDIAN STATEMENT (Please complete the appropriate statement below).

1. I, the undersigned parent/ guardian of_____, request that a school nurse or trained school employee administer the above medication according to the provider's instructions. I agree to furnish the necessary prescribed medicine in the properly labeled container and to provide replacement medication as necessary. I agree to notify the school nurse immediately if the medication prescription is changed.

2. I, the undersigned parent/ guardian of_____, believe she/he is competent to carry and administer her/his own medication (excluding controlled substances) according to the provider instructions above at the appropriate time and in the appropriate manner. I give permission for her/him to do so.

Implementation of these orders and care includes authorization to contact the healthcare provider to discuss this medication and the condition and elements of care needed for this condition. Without this authorization these orders will not be implemented.

Parent/Guardian Signature: _____ Date: _____

Home Phone:_____ Work Phone(s): _____

Medication discontinued per: parent: _____ (provider notified: _____Date: _____)
Medication discontinued per: provider: _____Date: _____