ALBUQUERQUE PUBLIC SCHOOLS
PHYSICIAN ORDER AND MEDICATION AUTHORIZATION FORM
(Please complete every item on this form.)

Student's Name: _____

Date of Birth: _____ School: _____

PHYSICIAN'S ORDER AND STUDENT COMPETENCY STATEMENT

1. I have examined this student for (diagnosis) _____ and have determined she/he requires medication during school hours.
2. Name of medication: _____ Dosage: _____

   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: _____
   _____
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

Physician's Signature: _____ Printed Name: _____

Date: _____ Phone: _____

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

1. I/We, the undersigned parent(s)guardian(s) of _____, believe she/he is competent to carry and administer her/his own medication (excluding controlled substances) at the appropriate time and in the appropriate way. I/We give my/our permission for her/him to do so.

2. I/We, the undersigned parent(s)/guardian(s) of _____, request that a school employee assist the student with the self-administration of the above medication, according to the physician's instructions. I/We agree to furnish the necessary prescribed medicine in the properly labeled container, to provide replacement medication as necessary, and I/we agree to notify the school nurse immediately if the physician or medication prescription is changed.

3. **FOR STUDENTS WHO HAVE A DISABILITY THAT PREVENTS THEM FROM SELF-ADMINSTRATION:** I/We, the undersigned parent(s)/guardian(s) of_____, request that a school nurse administer the above medication, to the student, according to the physician's instruction. I/We agree to furnish the necessary prescribed medication and I/we agree to notify the school nurse immediately if the physician or medication prescription is changed.

Parent/Guardian Signature: _____ Date: _____

Home Phone: _____ Work: phone: _____

Medication discontinued per: parent_____(physician notified:_____Date:_____)
Medication discontinued per: physician_____Date:_____

_____