

Albuquerque Christian School
Provider Order and Medication Authorization Form
(Please complete every item on this form)

Student Name: _____
Date of Birth: _____

Provider's Order and Student Competency Statement

1. I have examined this student for (diagnosis): _____ and have determined that they require medication during school hours.
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: _____

Healthcare Provider's Signature: _____ Printed Name: _____

Date: _____ Phone Number: _____ Fax: _____ Email: _____

Parent/Guardian Statement (Please complete the statement below)

1. I, the undersigned parent/guardian of _____, request that the school 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 immediately if the medication prescription is changed.

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: _____

Medication discontinued per: parent: _____ (Provider notified: _____ Date: _____)
Medication discontinued per: provider: _____ Date: _____