_____*Public Schools*

School District

PROVIDER ORDER /MEDICATION AUTHORIZATION FORM

Student Name: _____ DOB: _____

School: _____ Grade/Teacher: _____

. . . . . .

PROVIDER ORDER **(Please complete every item in this section)** **Date: _____**

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

2. Name of Medication: _____ Dosage: _____
   Route: _____ Time of administration:_____ Duration: _____

3. Special instructions regarding this medication:
   _____
   _____

4. Contact me if the following signs or symptoms develop: _____

Healthcare Provider Signature: _____ Printed Name: _____

Phone: _____ Fax: _____ Email: _____

. . . . . .

PARENT/GUARDIAN STATEMENT: **(This document is in effect for the current school year only)**

1. I, the undersigned parent/guardian of the above named student, hereby request the school nurse or designee administer the above medication according to the healthcare provider's instructions (above).
2. I agree to furnish the necessary prescribed medication in the properly labeled container, to provide replacement medication as necessary and to notify the school nurse immediately if the provider or medication prescription is changed or discontinued.
3. I authorize, as needed, the sharing of information related to my child's health between the school nurse (and designee) and the health care provider listed on this form. I understand without this authorization to communicate these orders will not be implemented.

Parent/Guardian Signature: _____ Date: _____

Home phone: _____ Alternate phone: _____

For Office Use Only **Medication expiration date: _____**

Medication discontinued date: _____ by ☐parent ☐provider (If parent provider notified: (_____) date

New Mexico