▪ ALBUQUERQUE ACADEMY ▪
HEALTH CARE PROVIDER'S MEDICATION ORDER AND AUTHORIZATION FORM
2022-2023 School Year

Please complete this form for medication to safely be administered during school hours on the Albuquerque Academy campus. Please fill out a separate authorization form for each medication***. This form is for prescription medication that is needed longer than 10 days, a controlled substance, OR an over-the-counter medication needed longer than 3 consecutive days.***

FOR PRESCRIBED ASTHMA, ALLERGY, DIABETIC OR SEIZURE MEDICATIONS THIS IS NOT REQUIRED. PLEASE ONLY COMPLETE AND PROVIDE THEIR EMERGENCY ACTION PLANS.

STUDENT'S NAME: _____ **DATE OF BIRTH**_____
Please Print Last First

HEALTH CARE 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: _____
3. Time of administration:_____ Duration of administration (how long?):_____
4. Please check this box if this medication is to be administered only when a morning dose of medication is forgotten at home (it is the parents' responsibility to contact school nurse and request medication be given). ☐
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**

Health Care Provider Signature: _____ Date: _____

Health Care Provider Name (print): _____ Phone: _____

PARENT/GUARDIAN STATEMENT – please complete the appropriate statement below:

1. I/We, the undersigned parent(s)/guardian(s) of _____, believe they are competent to **carry and administer** their own medication ***(excluding controlled substances)*** at the appropriate time and in the appropriate way. I/We give my/our permission for them to do so. I/We agree that my/our child will carry the medication in a pharmacy labeled container with only the amount of medication required for the day.
2. I/We, the undersigned parent(s)/guardian(s) of _____, request that either **the school nurse or a designated school employee** administer the above medication according to the health care provider'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 health care provider or medication prescription is changed.

Parent/Guardian Signature: _____ Date: _____
Home/ CELL/ Work Phone: _____

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AUTHORIZATION TO ADMINISTER SHORT-TERM MEDICATION

2022-2023 School Year

This form is to be completed for non-controlled substance medications needing to be administered by the Health Office for an anticipated or planned time span of less than 10 days. Any over-the-counter medication that is administered for more than 3 consecutive days must use the *On-Campus Long-Term Medication Authorization Form* completed by an overseeing provider.

DATE_____STUDENT'S NAME_____DATE OF BIRTH_____
Last First

NAME OF DRUG_____DOSAGE_____TIME OF ADMINISTRATION_____

DURATION OF TIME STUDENT WILL BE ON THIS MEDICATION_____

SPECIAL INSTRUCTIONS REGARDING MEDICATION_____

PRESCRIBER NAME_____ PRESCRIPTION #_____

DISPENSING PHARMACY_____PHONE #_____

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PARENT/GUARDIAN STATEMENT: (Please fill out (A) or (B) below and complete form.

(A) I/We, the undersigned parent(s) guardian(s) of _____ believe they are competent to carry and administer their own medication at the appropriate time and in the appropriate way. I/We agree that my/our child will carry the medication in a pharmacy labeled container with only the amount of medication required for each day that they need the medication.

(B) I/We, the undersigned parent(s)/guardian(s) of _____ request that either the school nurse administer or a school employee assist the student with 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 to notify the school nurse immediately if the health care provider or medication prescription is changed.

_____	_____	_____	_____
Home Phone	Business/Cell Phone	Parent's/Guardian's Signature	Date

▪ A L B U Q U E R Q U E A C A D E M Y ▪

AUTHORIZATION TO ADMINISTER MEDICATION FOR OFF-CAMPUS ACTIVITIES

2022-2023 School Year

It is important that Albuquerque Academy School activity sponsors are aware of any medication that your child may be taking that could affect their wellbeing during an off-campus activity (e.g. antibiotics, allergy medications, etc). In order for this medication to be safely administered during school activities outside of a regular school day, please complete every item on the upper portion of this form. Medication administration will be handled in the following way:

1. The school employee leading the activity will carry and supervise the student's self-administration of the medication. **All medications**, including but not limited to controlled substances (e.g., Ritalin, Dexedrine, Codeine) **will be carried and dispensed by the school employee leading the activity.**
2. Exceptions: The student may carry and self-administer emergency medication such as epinephrine, albuterol, insulin, and glucagon as well as birth control pills.
3. All prescription medication, whether carried by the student (emergency medication only), or by the school employee leading the activity, will be in a pharmacy labeled container with only the amount of medication required for the duration of the trip or activity.

Please provide ONLY the amount of medication required for the duration of the activity.

DATE OF ACTIVITY/TRIP_____

STUDENT'S NAME_____**DATE OF BIRTH**_____**GRADE**_____
Last First

NAME OF DRUG_____ **DOSAGE** _____**TIMES OF ADMINISTRATION**_____

DURATION OF TIME STUDENT WILL BE ON THIS MEDICATION_____

SPECIAL INSTRUCTIONS REGARDING MEDICATION_____

PRESCRIBER NAME_____ **PRESCRIPTION #**_____

DISPENSING PHARMACY NAME_____**PHARMACY PHONE #**_____

PARENTAL/GUARDIAN STATEMENT (Please complete the appropriate statement below):

1. I/We, the undersigned parent(s)/guardian(s) of _____, request that the school employee leading this activity carry the medication and supervise my/our child's self-administration of this medication. I/We agree to provide the medication in a pharmacy labeled container with only the amount of medication required for the duration of the activity. This is MANDATORY for all medications that are not classified as emergency medications or hormonal contraceptive (i.e. albuterol, EpiPen, insulin, Glucagon).

PARENT/GUARDIAN SIGNATURE:_____**DATE**:_____

PARENT/GUARDIAN HOME/ WORK/ CELL PHONE_____