LOS LUNAS SCHOOLS
MEDICATION AND/OR NURSING PROCEDURE AUTHORIZATION FORM

Medication will be administered in the school ONLY when it is necessary for a student to remain in school. Medication should be sent to school with or for a student **ONLY WHEN IT IS ABSOLUTELY NECESSARY.**

Medications ordered QD or BID are not administered in school unless medical justification is documented by a physician providing rationale for time of administration.

The purpose of this policy is to ensure that students do receive necessary medication according to their physician's orders and to ensure maximum safety for all concerned. Please understand that your signature on this form authorizes other school personnel to supervise your child with self-administration of medication when the school nurse is not available.

Should you be asked to complete one of these forms, please read the form thoroughly and respond to ALL items. Contact the school nurse if you have any questions. THANK YOU.

One form must be filled out **ANNUALLY** for EACH PRESCRIPTION or NON-PRESCRIPTION medication or NURSING PROCEDURE.

PHYSICIAN'S STATEMENT

Date:_____ School:_____

School Phone Number: _____ School Fax Number: _____

Student's Name: _____ Student's Date of Birth: _____

Diagnosis: _____

Name of Medication: _____ Dosage: _____

Time of Administration: _____ Duration of Administration: _____

Special Instructions for Medication/Nursing Procedure: _____

_____ Student may self-administer under direct supervision of a designated, trained staff person. Medication will be locked up in the Nurse's Office per Los Lunas School Board Policy # 7.21.

_____ Student may self-administer without supervision per Los Lunas School Board Policy #7.21.

Physician's Signature: _____ Phone: _____

Physician's Name Printed: _____

PARENT/GUARDIAN STATEMENT

I/We, the parent(s) of _____(Student's Name) hereby request that this medication be given to my/our child according to the physician's instructions.

I/We agree to furnish the necessary medication in a pharmacy/original labeled container, to provide replacement medication as necessary, and to provide a new physician's statement if there is ANY change in the medication, dosage, administration time, administration route, or special instructions regarding medication. I/We understand that other designated personnel (other than the school nurse) may supervise the child with self-administration of medication. **If unable to self-administer, the parent will come and give medication when nurse is unavailable.**

Parent/Guardian Signature:_____ **Date:** _____

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