PARENT/GUARDIAN AUTHORIZATION for PRESCRIPTION (RX) MEDICATION ADMINISTRATION

*(*This order must be signed by providers with prescriptive rights & practice in New Mexico)*

I, the Parent/Guardian, request the staff of Bloomfield School District to assist in the administration of the medication NECESSARY DURING SCHOOL HOURS as ordered by the medical provider to my child.

Refer to BSD Board Policy J-5381 © JLCD-E

Student Name: _____ SCHOOL ID: _____ DOB: ___/____/____ SY _____

Parent/Guardian Signature: _____ Date: ___/___/_____

⬜ I understand that if my student takes more than one prescribed medication each medication will require its own completed form. (Parent/Guardian Initials _____)

⬜ PRESCRIPTION (RX) MEDICATION MUST BE PROVIDED IN THE ORIGINAL PHARMACY LABELED CONTAINER. **Ask the pharmacist for an additional labeled medicine container; one for home and one for school.* (Parent/Guardian Initials _____)

⬜ If there are any changes in dose or medication is discontinued by the medical provider, the school health office will be notified and submit a new authorization form. The medical provider order or written parent request to discontinue must be on file. (Parent/Guardian Initials _____)

⬜ I understand that for the safety of all students, all prescription medication must be (a) transported to/from school by an adult and (b) kept locked in the health office except authorized emergency medications. (Parent/Guardian Initials _____)

⬜ I understand that I will be notified when my student's prescription is running low and that it is my responsibility to provide the health office with a refill. (Parent/Guardian Initials _____)

***HEALTH CARE PROVIDER AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL**

MEDICAL DIAGNOSIS	NAME OF MEDICATION	SCHOOL DOSE	TIME(S)

Please list any possible side effects: _____

Food/Drug Allergies: Y/N (If yes, please explain: _____)

Provider Name & Contact Information:_____

_____Fax:_____

Provider Signature:_____ Date: _____/_____/_____

Provider may FAX authorization/order to: _____ ATTN: Health Office Staff

Health Office Use Only

Received and counted by: _____

School Nurse Signature: _____ Date: ____/____/_____

⬜ Medication has been entered into PowerSchool.