PHYSICIAN ORDER AND MEDICATION AUTHORIZATION FORM
Student Medication must accompany this form
Please complete every item on this form

Student's Name: _____

Date of Birth: _____ School: _____ Grade: _____

This form must be completed fully in order for schools to administer required medication. A new medication administration form must be completed for each year, for each medication, and each time there is a change in dosage or time of medication administration.

- Prescription medication must be in an original container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- An adult must bring the medication to the school.
- The School Nurse will share information relevant to the prescribed medication as he/she determines appropriate for your child's health and safety.

PHYSICIAN'S ORDER AND STUDENT COMPETENCY STATEMENT

1. I have examined this student for (diagnosis) _____ and have determined she/he requires medication during school hours.
2. Name of medication: _____ Dosage: _____
   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: _____
   _____
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

Physician's Signature: _____ Printed Name: _____

Date: _____ Phone: _____

PARENT/GUARDIAN STATEMENT (Please complete the appropriate statement below.)

1. I/We, the undersigned parent(s)guardian(s) of _____, believe she/he is competent to carry and administer her/his own medication (excluding controlled substances) at the appropriate time and in the appropriate way. I/We give my/our permission for her/him to do so.

2. I/We, the undersigned parent(s)/guardian(s) of _____, request that a school employee assist the student with the 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 I/we agree to notify the school nurse immediately if the physician or medication prescription is changed.

3. Recognizing that the Texico Municipal Schools are under no obligation to administer such medication, I hereby waive any claim for injury against Texico Municipal Schools or its employees, arising from, the administration of such medication. Furthermore, I agree to indemnify the Texico Municipal Schools and its agents and employees for any claims, suits, judgments, or costs of defense (including attorneys' fees) arising from any such claims.

Parent/Guardian Signature: _____ Date: _____

Home Phone: _____ Work: phone: _____

Medication discontinued per: parent_____(physician notified:_____Date:_____)

Medication discontinued per: physician Date:_____