PROVIDER / PARENT MEDICATION AUTHORIZATION FORM

Name: ____ DOB: ______________________________

Special Program : _______________________________ 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 special program to 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 special program 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 special program (or 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: (_________)**

New Mexico