

**TAOS CHARTER SCHOOL
PHYSICIAN ORDER FOR MEDICATION AT SCHOOL**

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 AN ABSOLUTE NECESSITY**.

This form needs to be complete and returned to the school nurse before any medication can be administered. It is school policy that all medication (prescriptions and over the counter) be stored in the nurse's office and dispensed by the school nurse or a designated school employee in her absence. Students are not allowed to carry medication at school unless ordered by their physician. Call the school nurse with any concerns.

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

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

PHYSICIAN'S ORDER and Student Competency Statement: (To be completed by physician)

I have examined this student for (diagnosis) _____ and have determined he/she requires medication during school hours.

Medication _____ Dosage _____ Time _____ Route _____

This student is expected to be receiving this medication (how long?) _____

Special instructions regarding this medication _____

Contact me if the following signs or symptoms appear _____

I believe this student is both capable and responsible for self-administering this medication at school.

No Yes, Supervised Yes, Unsupervised, Student may carry medication at school

Physician's Signature: _____ Phone: _____

Physician's Name (Please Print): _____ Date: _____

PARENT/GUARDIAN STATEMENT: (To be completed by parent/guardian)

I/We, the parent(s)/guardian(s) of _____ (Student's Name)

1. Give permission for my child to receive the above medication at school as ordered by our physician.
2. Agree to furnish the school nurse with the ordered medication in the original pharmacy labeled container.
3. Agree to provide replacement medication to the school nurse as necessary during the school year.
4. Agree to notify and/or provide the school nurse in writing with ANY changes regarding this medication. For example: A change in medication, dosage, administration time, route, medication is discontinued or any special instructions regarding this medication not listed here.
5. Understand that in the nurse's absence, this employee _____ will assist my child in taking his/her medication at school.
6. Agree to not hold Taos Charter School and its employees liable.

Parent's/Guardian's Signature: _____ Date: _____

Home phone _____ Work phone _____ Cell phone _____

SCHOOL NURSE AUTHORIZATION for medication _____

SCHOOL NURSE STATEMENT: (To be completed by the school nurse)

Date Medication Order received at school _____ School Nurse _____

Medication discontinued on this date: _____ By Parent Physician