COTTONWOOD CLASSICAL PREPARATORY SCHOOL

PROVIDER ORDER / MEDICATION AUTHORIZATION FORM

Student Name: ___________________________  DOB: _______  Grade: _______

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 school nurse or designee 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 school nurse 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 school nurse (and 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: ___________________________

Medication expiration date: ____________

Medication discontinued date: ___________________________  by □parent □provider (If parent provider notified: ______) date

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A PUBLIC SCHOOL AT

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