BOSQUE SCHOOL
PHYSICIAN ORDER AND MEDICATION AUTHORIZATION FORM
(Please complete every item on this form)

Student's Name

Date of Birth School Bosque School

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 his/her 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

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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 his/her 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 administration immediately if the physician or medication prescription is changed.

3. **FOR STUDENTS WHO HAVE A DISABILITY THAT PREVENTS THEM FROM SELF-ADMINISTRATION**:

I/We, the undersigned parent(s) guardian(s) of ,
request that a school employee administer the above medication, to the student, according to the physician's instruction. I/We agree to furnish the necessary prescribed medication and I/we agree to notify the school administration immediately if the physician or medication prescription is changed.

Parent/Guardian Signature Date

Home Phone Work: Phone

Medication discontinued per: parent ☐ (physician notified: ☐ Date)
Medication discontinued per: physician ☐ Date