An Important Note from our School Nurse

Dear Think Academy Summer Parents:

The Albuquerque Academy Nurse's Office would like to extend our warm welcome to the Think Academy Summer Program! If you have questions or concerns about your child's health during your child's time with us, please do not hesitate to contact our office at **858-8851**. If we are not available when you call, please feel free to leave a detailed message and we will return your call as quickly as possible.

MEDICATIONS

Recognizing that some children may need to take prescription medication during the day, we would like to take this opportunity to inform you of our medication administration policy:

- ALL prescription medication (e.g., albuterol inhalers, epi pens) brought to school must have a Health Care Provider's Medication Order and Authorization Form completed prior to the start of Think Academy Summer. If possible, please administer prescription medications at home.
- Students may NOT carry and/or self-administer controlled substances, e.g., Ritalin, Dexedrine, codeine-based medications; these medications must be held and administered in the nurse's office (see below)
- If medication must be given during school hours…please complete the **Health Care Provider's Medication Order and Authorization Form** (see reverse) for each medication.
  Form Instructions:
  - **Health Care provider** (M.D., N.P., P.A.)…Complete and sign the top portion of the form.
  - **Parent/guardia**n…Complete and sign the bottom portion of the form.
  - You may hand deliver a completed form to the Nurses Office, scan and email it (silva@aa.edu), or fax it to 858-8886.
  - Provide medication in a pharmacy-labeled container that holds the appropriate amount of medication to be administered.
- If your child has one of the conditions listed below, please complete the appropriate **Action Plan** in addition to the **Health Care Provider's Medical Order and Authorization Form.** Contact the Nurse's Office (858-8851) to request the necessary form:
  - **Asthma Action Plan**
  - **Allergy Action Plan** (for severe anaphylactic allergies only)
  - **Seizure Action Plan**
  - **Diabetes Medical Management Plan** and a **Diabetes Emergency Action Plan**

  IMPORTANT! Medication will NOT be administered without a completed Health Care Provider's Medical Order and Authorization Form on file.

As summer approaches, if you have questions about this policy or any other matter concerning the health of your child, we encourage you to contact our office at **858-8851**.

Sincerely,

Jen Duvall

CFNP, RN, MSN, MPH
School Nurse, Albuquerque Academy

Health Care Provider's Medication Order and Authorization Form

For medication to be safely administered during school hours on the Albuquerque Academy campus, please complete every item on this form. Please fill out a separate authorization form for each medication. If you have any questions, please call Jen Duvall, School Nurse, at 858-8851. **FOR PRESCRIBED ASTHMA MEDICATION, PLEASE COMPLETE THE ASTHMA ACTION PLAN. FOR PRESCRIBED EPI-PEN, PLEASE COMPLETE THE ALLERGY ACTION PLAN.**

STUDENT'S NAME _____ DATE OF BIRTH _____
Please Print Last First

HEALTH CARE PROVIDER'S ORDER AND STUDENT COMPETENCY STATEMENT:

1. I have examined this student for (diagnosis) _____ and have determined that he/she requires medication during school hours.
2. Name of medication _____ Dosage _____
3. Time of administration _____ Duration of administration (how long?) _____
4. Please check this box if this medication is to be administered only when a morning dose of medication is forgotten at home. (It is the parents' responsiblity to contact school nurse and request medication be given.) ☐
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**

Health Care Provider Signature _____ Date _____

Health Care Provider Name (print) _____ Phone _____

PARENT/GUARDIAN STATEMENT - please complete the appropriate statement below:

1. I/We, the undersigned parent(s)/guardian(s) of _____, believe he/she 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. I/We agree that my/our child will carry the medication in a pharmacy-labeled container with only the amount of medication required for the day.
2. I/We, the undersigned parent(s)/guardian(s) of _____, request that either the school nurse administer or a designated school employee administer the above medication according to the health care provider'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 health care provider or medication prescription is changed.

Parent/Guardian Signature _____ Date _____

Home Phone _____ Work Phone _____