

Medication Order Form for Nyack Public School District

Student Name: _____, Date of Birth: _____

I, _____ give permission for the school nurse to administer medication as per the physician's orders below. I also give permission for the nurse to contact my child's physician concerning any medication issues that may arise.

Parent/Guardian - Print Name

Parent/Guardian - Signature

Date

For medical reasons, an RN is required / is not required to accompany this student on all field trips.
Please circle one

PHYSICIAN ORDERS -Over-the-Counter Medications

Please note –MD please initial the appropriate box for EACH medication prescribed.

DRUG	ROUTE	DOSAGE	SCHEDULE	MD INITIALS	COMMENTS
Tylenol	PO Tabs, Chewable or Liquid	Per label instruction by age/weight	Q 4 hr PRN for pain or fever > 100.0 F		
Ibuprofen	PO Tablet or liquid	Per label instruction by age/weight	Q 6 hr PRN for pain or fever > 100.0 F		
Benadryl	PO Caplets or liquid	Per label instruction by age/weight	Q 6 hr PRN for allergic reaction (hives/insect bite)		

Prescription Medications*** – Must be supplied to Nurse's Office in original container.

DRUG	ROUTE	DOSAGE	SCHEDULE	MD INITIALS	COMMENTS
Epi-pen or Epi-pen Jr	IM	0.3mg or 0.15mg	For severe allergic reaction with respiratory compromise		Allergic to: <input type="checkbox"/> May self carry <input type="checkbox"/> To be kept in Nurse's Office
Inhaler Type:	Asthma Inhaler	2 puffs PRN	Q _____ hr For acute asthma episode		<input type="checkbox"/> May self carry <input type="checkbox"/> To be kept in Nurse's Office
Insulin -Type:	SQ Injection or InsulinPum p				Please attach diabetic coverage orders
Glucagon	IV, IM or SQ	1 mg or 0.5mg	For severe hypoglycemic reaction		

***For all other medications, please attach a copy of the MD prescription to this form.

*There is a Nebulizer in the Nurse's Office, please send in tubing and medication if indicated.

Physician Signature: _____

Date: _____

MD Stamp required: