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 <u>required</u> / <u>is not required</u> 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 Capletsor 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: ☐ May self carry ☐ To be kept in Nurse's Office
Inhaler Type:	Asthma Inhaler	2 puffs PRN	Q _____ hr For acute asthma episode		☐ May self carry ☐ To be kept in Nurse's Office
Insulin –Type:	SQ Injection or InsulinPump				**Please attach diabetic coverage orders**
Glucagon	IV, IM or SQ	1 mg or 0.5mg	For severe hypoglycemic reaction		

***<u>For all other medications</u>, 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: