

REQUIRED FOR MEDICATION ADMINISTRATION IN SCHOOL

**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

**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 Tablets 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.**

MS & HS students may self carry Asthma & Allergy medication with completed MD orders.

This does not apply to Elementary level students.

DRUG	ROUTE	DOSAGE	SCHEDULE	MD INITIALS	COMMENTS
<b>Epi-pen</b> or <b>Epi-pen Jr</b>	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
<b>Inhaler Type:</b>	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
<b>Insulin –Type:</b>	SQ Injection or InsulinPump				<b>Please attach Diabetic Management Plan.</b> <input type="checkbox"/> Student is self directed (HS only) and may text blood glucose to school RN as indicated.
<b>Glucagon</b>	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:**