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

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.
MS & HS students may self carry medication with MD orders, this does not apply to Elementary level students.

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: