Greenville Elementary School

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SCARSDALE, NEW YORK 10583

HEALTH OFFICE
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MEDICATION AUTHORIZATION FORM

Individualized Orders for: _____ D.O.B. _____ Grade ____

ALLERGIES: _____

1. **Standard Over-the-Counter/PRN Medications:** The following medications are the only ones available in the health office. For any other medications, see below. These medications will be administered at the discretion of the R.N. per label instruction by age and weight, or as specified by M.D., ***only if signed approval is indicated by BOTH the student's physician AND parent.***

DRUG	Route	*Dosage*	Schedule & Indication	Provider order
Tylenol tabs/acetaminophen	po	325 mg 650mg	Q4 hr. prn ,pain or fever	**YES** or **NO** (Please circle)
Advil tablets/ ibuprofen	po	200mg 400mg	Q6 hr. prn ,pain or fever	**YES** or **NO** (Please circle)
Throat Lozenges	po	1 drop	1- Q2 hr. prn sore throat	**YES** or **NO** (Please circle)
Benadryl	po	25mg 50mg	Q 4 hr. allergic reaction/ hives	**YES** or **NO** (Please circle)

2. **PRESCRIPTION and any other Over-the-counter Medications:** PHYSICIAN, please complete with the patient's current regimen for both scheduled and PRN medications.

DRUG	Route	*Dosage*	Schedule & Indication	Comments

**** All prescription medications must be provided directly to the nurse by a responsible adult in the original container with your student's name on it**

Physician Signature: _____ **Date:** _____ **License #:** _____ **Phone #:** _____

***** I authorize the school RN (and on trips, the EMT/ authorized chaperone) to dispense the medication prescribed by the above physician:***

***Parent signature:** _____ **Date:** _____