EDGEMONT JUNIOR-SENIOR HIGH SCHOOL

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HEALTH OFFICE
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MEDICATION AUTHORIZATION FORM

Individualized Orders for: ________________________________ D.O.B. ________ Grade ____

Allergies: ____

1. <u>Standard Over-the-Counter/PRN Medications</u>: The following medications are the *only* ones available in 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 Name	**Route**	***DOSAGE***	**Schedule & Indications**	**Comments**
Tylenol tablets (acetaminophen)	po	325 mg. 650 mg.	Q4 hr. as needed for pain or fever	
Advil tablets (ibuprofen)	po	200 mg. 400 mg.	Q6 hr. as needed for pain or fever	
Benadryl capsules (diphenhydramine hydrochloride)	po	25 mg. 50 mg.	Q4 hr. as needed for allergic reaction, hives	
TUMS	po	500mg 1 Gm.	PRN as needed for indigestion/upset stomach	

2. <u>PRESCRIPTION and any other Over-the-Counter Medications</u>: PHYSICIAN, please complete with patient's current regimen for both scheduled and PRN medications.

<u>*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.</u>

Drug Name	**Route**	***DOSAGE***	**Schedule & Indications**	**Comments**

Physician Signature: ____________________________________ **Date:** __________________

License #:____ **Phone #:** __________________

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

****Parent signature**: _____________________________________ **Date:** _________________