

Written Medication Order and Authorization Form

BISHOP GRIMES JR./SR. HIGH SCHOOL
6653 Kirkville Rd, East Syracuse, NY 13057
Health Office Ph. (315) 463-8917, Fax (315) 437-0358

last name	first	grade	school year	date
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The school nurse will dispense **ALL** medication (prescription and over the counter-OTC) only with parental permission **AND** the licensed prescriber's written order. These medications must be brought to the health office in their original labeled containers. Complete the following section for all medications other than those noted below.

	name	dose/route	frequency/time	reason
1.	_____			
2.	_____			

parent/guardian signature	signature of MD, PA, or RNNP/stamp
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The over the counter medications listed below will be provided by the school and dispensed by the nurse with parental permission **AND** the licensed prescribers signature. Parent/guardian, check the box (es) of the medication(s) you permit your child to receive from the school nurse as needed.

- Acetaminophen 325 mg, one to two tablets orally, every 4 hours as needed per package directions for headache pain or menstrual cramps.
- Ibuprophen 200 mg, one to two tablets orally, every 4 hours as needed per package directions for headache, muscle aches, joint pain or menstrual cramps

parent/guardian signature	signature of MD, PA or RNNP/stamp
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Self-carry authorization is for asthma inhalers and epi-pens only.

- | | name | dose/route | frequency | reason |
|------------------------|-------|------------|-----------|--------|
| • Asthma inhaler order | _____ | | | |
| • Epi pen order | _____ | | | |

My child has my permission and his/her licensed prescriber's authorization to properly use and carry his/her:

- asthma inhaler epi-pen
- Our licensed prescriber has instructed my child in the proper use, purpose and administration of this medication.

parent/guardian signature	signature of MD, PA or RNNP/stamp
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