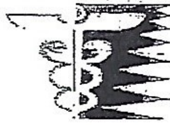
Seely Place Elementary

HEALTH OFFICE



MEDICATION AUTHORIZATION FORM

Individualized Orders for: ______________________________ D.O.B. ______________

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 RN, ***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		Q___ Hr. for:	
Advil tablets (ibuprofen)	po		Q___ Hr. for:	
Throat Lozenges	po		Q___ Hr. for:	
Benadryl capsules (diphenhydramine hydrochloride)	po		Q___ Hr. for:	

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

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

Drug Name	Route	Dosage	Schedule & Indications	Comments

Physician Signature: ______________________________ Date: ______________

License #: ______________________________ Phone #: ______________

*****I authorize the school RN to dispense the medication prescribed by the above physician:***

Parent signature: Date: