Written Medication Order and Authorization Form

BISHOP GRIMES Jr/Sr HIGH SCHOOL
6653 Kirkville Rd, East Syracuse, NY 13057
Health Office 463-8917 or 437-0356 Fax 437-0358

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last name first grade school year date

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

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.
[ ] Ibuprofen 200 mg, one to two tablets orally, every 4-6 hours as needed per package directions for headache, muscle aches, joint pain or menstrual cramps

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

Self-carry authorization is only for asthma inhalers & EpiPen/AuviQ

name dose/route frequency reason

- Asthma inhaler order____
- Epi Pen/Auvi-Q order____

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

[ ] asthma inhaler [ ] epi-pen/Auvi-Q

[ ] Our licensed prescriber has instructed my child in the proper use, purpose and administration of this medication**.**

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