Menands Union Free School District
19 Wards Lane, Menands, NY 12204-2197
Phone: 5118-465-4561 Fax518-434-2840

Over The Counter Medication Orders

To be completed and signed by the student's Licensed Health Care Provider
(New York State law requires that all medication for students be patient specific)

Name: ______________________________ **Date of Birth:** ___________

Medication Name	Dosage & Indication for use	Physician Approval Initials	Parent Approval Initials	Concerns/ Comments
Acetaminophen (Tylenol)	Per label instructions. Per age/wt			
Ibuprofen (Motrin)	Per label instructions. Per age/wt			
Triple Antibiotic Ointment	Per Label Instructions			
Caladryl (Anti-Itch) Lotion	Per Label Instructions			
Sunscreen/ Sunburn lotion	Per Label Instructions			
Medicaine (Insect Bite) swabs	Per Label Instructions			
Cough Drops	Per Label Instructions			Gr 4-8 only

Physician's Signature:______________________________ Date:______________

Physician's Name Printed: ____

Address: ____ Phone:______________

Parent/Guardian: ____________________________________Date:_____________

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PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the parent or guardian:

I request that my child ______________________________DOB ____________ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

PLEASE CHECK ONE:

☐ I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips to my **self directed child**

☐ I understand that administration of oral, topical or inhalant medications to my **non self-directed child** and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

Signature (Parent or Guardian): ____

Telephone: Home ___________________ Work ___________________ Date ______________

B. To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Name of Student ______________________________________ DOB _______________

Diagnosis: ____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

Physician's Signature __________________________________ Date:_________________

Address: ____ Phone:_________________

* Medication must be in original pharmacy labeled container with specific orders and name of medication.

* Medication and refills must be brought to school by parent, guardian or responsible adult.

Plan reviewed with parent(s)/guardian(s):

Parent Signature:____________________________________Date:____________________

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