



No medications will be administered by the school nurse or designated personnel without the written authorization of a physician and parent.

Child's Name _____ Grade 2010-2011 _____
Drug Allergies _____

PHYSICIAN: Please indicate by checking and signing below which standing orders for the following non-prescription medicines are approved for this student to receive from the School Nurse at Ravenscroft:

For Pain:	Acetaminophen, Ibuprofen
For Sore Throat:	Acetaminophen, Ibuprofen, Chloraseptic spray, cough drops
For Cold Symptoms/ Allergies:	Sudafed, Benadryl, Triaminic
For Cough:	Robitussin DM
For Stomach pain, nausea, diarrhea:	Mylanta, Tums, Imodium AD, Pepto-Bismol
For Menstrual cramps:	Acetaminophen, Ibuprofen, Midol
For Eye irritations:	Visine, Visine AC, Visine for Contacts, Re-wetting solutions
For Abrasions:	Polysporin
For Skin Irritations/ Rashes:	Caladryl , Calamine Lotion, Cortisone Cream, Lanacane Cr.

Dosage for a medication will be according to manufacturer's recommendations (age and weight appropriate) on the label unless otherwise indicated by the physician.

All of the Medications above _____ Medications checked _____ None of the above _____

*Physician Signature _____ Date _____

*Parent/Guardian Signature _____ Date _____
(*Both signatures required)

PRESCRIPTION MEDICATIONS

I request that my child be administered the prescription medication as indicated by the physician's order below: (For example, Inhalers, Insulin, Epi-pens or other required medications)

Parent/Guardian _____ Date _____

TO BE COMPLETED BY PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT:

Name and form of medication _____ Dosage _____

Route _____ Hours to be given: _____

Possible side effects: _____ Duration of order _____

Signature of Provider _____ Date _____

Student may self administer medications listed above: YES _____ NO _____