Medication Release Form

ST. DAVID'S SCHOOL YEAR 2010-2011

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

Student's Name _____ Grade _____

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 St. David's School.

Reason:	**Medication:**
Pain	Acetaminophen, Ibuprofen
Sore Throat	Acetaminophen, Ibuprofen, Cough drops
Allergies	Benadryl®
Cough	Cough drops, Robitussin® DM
Stomach pain, nausea	Tums®
Menstrual cramps	Acetaminophen, Ibuprofen, Midol
Eye Irritations/Contact Lens Care	Visine®, Re-wetting solutions, Eye wash
Abrasions	Polysporin®
Skin irritations/Rash/Burn	Hydrocortisone Cream, Burn Cream

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 circled _____ None of the above _____

***Physician Signature** _____ **Date** _____

***Parent 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, EpiPen®).
Parent Signature _____ Date _____

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

_____ _____ _____
Name and form of medication Dosage Time to be Given

_____ _____
Duration of Order Possible Side Effects

_____ _____
Physician/Nurse Practitioner/Physician Assistant Signature **Date**

Physician Address/Phone Number _____

Student may self administer medications listed above: Yes: _____ No: _____

Health Forms Attached: Diabetes Care Plan:_____ Severe Allergy Action Plan:_____
Asthma Action Plan:_____ Health Care Plan (List Condition): _____