# CHAPPAQUA CENTRAL SCHOOL DISTRICT

## MEDICATION PHYSICIAN AUTHORIZATION FORM

****New York State Law requires this form to be FILLED OUT BY A PHYSICIAN and signed by a parent in order for our nurses to dispense medication to your child when needed. Prescription meds must be in original labeled container brought in by a parent.

**Student name:** ___________________________________ **D.O.B.** _____________________ **Weight:** ________________

| DRUG NAME | ROUTE | DOSAGE | SCHEDULE | PROVIDER ORDER | COMMENTS |
|---|---|---|---|---|---|
| Prescription medication: | | | | X | |
| Prescription medication: | | | | X | |
| Prescription medication: | | | | X | |
| Bacitracin/Neosporin Ointment | Apply to affected area TID | Per label instruction | PRN As per label instructions | Yes No | |
| Calamine | Apply to affected area TID | Per label instruction | PRN As per label instructions | Yes No | |
| Antacid (Tums) | PO liquid or chewable | Per label instruction | PRN As per label instructions | Yes No | |
| Diphenhydramine (Benadryl) | PO liquid or tablet | Per label instruction | PRN Q 6-8 hours for pain or fever > ______ | Yes No | |
| Ibuprofen | PO liquid or tablet | Per label instructions | PRN Q 6-8 hours for pain or fever > ______ | Yes No | |
| Tylenol/Acetaminophen | PO liquid or tablet | Per label instructions by age/weight | PRN Q 4 hours for pain or fever > ______ | Yes No | |

**Healthcare Provider Name**: _________________________ ______________________________ **STAMP**

**(Print)** **(Signature)**

**Parent's Signature**: ________________________________________ **Date:** __________________

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