SFASD

INDIVIDUAL ORDER for Spring-Ford Over-the-Counter Medications

Student Name _____ DOB _____

School / Grade _____ School Year _____

In accordance with school policy, medication(s) should be given at home before and/or after school. However, when this is not possible, prior to receiving the medication at school, this form must be completed and signed by a parent and physician. A new form and signatures are required each school year. All medications below are available in the health suite.

Prescriber's Authorization for OTC Meds at school

Check medication permitted - complete dose appropriate for student - sign below.

	Medication:	Dose:		Route:	Frequency:
☐	Acetaminophen	_____	mg	PO	q 4-6 hrs PRN
☐	Ibuprofen	_____	mg	PO	q 6-8 hrs PRN
☐	TUMS (Antacid)	_____	tab(s)	PO	q 4 hrs PRN

Prescriber's Signature _____ Date _____

Prescriber's Name/Title (print) _____Phone _____

Parent / Guardian Authorization

I give my permission for my child, _____, to receive the above medication ordered by a licensed prescriber during the school day. I understand that the medications will be given by school health personnel according to my child's licensed prescriber's directions.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Name (print) _____ Phone _____