Wentzville School District
Non-Prescription Medication Authorization Form

School: _____ **Phone:** (____) _____-_____ **Fax Number:** (____) _____-_____

Student: _____ **Date of Birth:** _____/_____/_____ **Grade:** _____

Tylenol/Acetaminophen

☐ Liquid 160mg/5ml _____ mls PO Q 4-6 hrs prn pain/fever

☐ Chewable 80mg _____ tabs PO Q 4-6 hrs prn pain/fever

☐ Tablets 325mg _____ tabs PO Q 4-6 hrs prn pain/fever

☐ Tablets 500mg _____ tabs PO Q 4-6 hrs prn pain/fever

☐ Other dosing: _____

Advil/Motrin/Ibuprofen

☐ Liquid 100mg/5ml _____ mls. PO Q 4-6 hrs prn pain/fever

☐ Chewable 50mg _____ tabs PO Q 6-8 hrs prn pain/fever

☐ Junior tabs 100mg _____ tabs PO Q 6-8 hrs prn pain/fever

☐ Tablets 200 mg _____ tabs PO Q 6-8 hrs prn pain/fever

☐ Other dosing:_____

Benadryl/Diphenhydramine

☐ Liquid 12.5mg/5ml _____ mls. PO Q 4-6 hrs prn allergy sx

☐ Chewable 12.5mg _____ tabs PO Q 4-6 hrs prn allergy sx

☐ Tabs/Caps 25mg _____ tabs/caps PO Q 4-6 hrs prn allergy sx

☐ Other dosing: _____

Allergy (antihistamine) Eye Drops

☐ OTC Allergy eye drops: 1 drop OU Q 8-12 hrs prn eye allergy sx

☐ Zyrtec or ☐ Claritin (please check one)

☐ Liquid 12.5mg/5ml _____ mls. PO Q day prn allergy sx

☐ Chewable 5mg _____ tabs PO Q day prn allergy sx

☐ Tablets 10mg _____ tabs PO Q day prn allergy sx

☐ Other dosing: _____

Other (FDA approved only)

☐ Other Dosing: _____

_____

_____

Over the Age of 12 years

☐ **Aleve/Naproxen** tabs/caps 220mg ____ tabs PO Q 8-12 hours prn pain

☐ **Excedrin Extra Strength**: Acetaminophen 250mg/Aspirin 250mg/Caffeine 65 mg tabs _____ tabs PO Q 6-8 hours prn headache

☐ **Midol Complete Tabs:** Acetaminophen 500mg/Caff 60mg/Pyrilamine maleate 15mg tab _____ tabs PO Q 6 hours prn cramps/bloating/pain

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PHYSICIAN AUTHORIZATION

Prescriber's Name/Title: _____

Telephone: _____ Fax: _____

Prescriber's Signature: _____
(MD, NP, Or PA signature or signature stamp ONLY)

Date: _____/_____/_____

Use for Prescriber's Address Stamp

PARENT/GUARDIAN AUTHORIZATION

I request designated school personnel to administer the medication prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I authorize the school nurse to communicate with the healthcare provider as allowed by HIPAA.

Parent/Guardian Signature: _____ **Date:** _____

This form is valid starting on the date signed by physician and will be in effect until the end of the current school year/summer session. Non-prescription medication must be in the original container with the label intact. An adult must bring the medication to school.