

Blair Academy Center for Health & Well-Being

2 PARK STREET BLAIRSTOWN, NEW JERSEY 07825 | TEL: 908-362-2010 | FAX: 908-362-7885

MEDICATION ORDER FORM 2026-2027

Student Name: _____ Diagnosis: _____

Date: _____ Date of Birth: _____

Dear Licensed Prescriber: **(Please note Health Care Provider must be someone other than a parent)**

- School and state regulations require that these medications be administered from the school's Health Center and that a written medication order from the licensed prescribing provider be kept on file in the student's medical record.
- **Field Trips:** While at Blair, students frequently travel for team sporting events as well as academic and cultural pursuits. Toward this end, student medication will be given to the trip leader prior to the trip departure. Trip leaders will carry the medication for the duration of travel. By signing below you are indicating that the above named student has been properly trained in self administration of the medication(s). The student has the knowledge and ability to self-administer the below prescription and/or over the counter medication(s) supplied by the parent/guardian during travel/outings.
- **Pharmacy:** We work with **Acme Pharmacy** for prescriptions, refills and over the counter medications. (908) 362-1799 152 Route 94 Blairstown, NJ 07825. **ALL controlled substances:** we can only accept a ***one (1) month supply*** at a time. Please be sure to plan for your patient to obtain refill prescriptions from you so that there are little to no interruptions of the medication. Please feel free to contact the Health Center directly with any questions.

Medication Name	Dose	Frequency	Route	PRN Only (Yes or No)	Administer Stimulants on class days only (yes or no)	Comments/Diagnosis

OTC that may be given during field trips or at Blair Health Center (Parent must supply): Please check off Yes or No

Analgesics/Antipyretic	Y/N	Antihistamines	Y/N	Antitussive/Decongestant	Y/N	Creams	Y/N
Tylenol	Y/N	Benadryl	Y/N	Mucinex	Y/N	Hydrocortisone 1% Cream	Y/N
Ibuprofen	Y/N	Zyrtec	Y/N	Robitussin	Y/N	Sun Block/Sunscreen	Y/N
Naproxen	Y/N	Claritin	Y/N	Delsym	Y/N		

_____
HEALTH CARE PROVIDER NAME

_____
HEALTH CARE PROVIDER SIGN

_____
DATE

OFFICE ADDRESS AND PHONE NUMBER
PRINT OR STAMP