Roaring Brook Elementary School
Health Office
530 Quaker Road
Chappaqua, NY 10514

Suzanne Rota, RN, MSN
914-238-7205 Ext. 6104
Fax 914-817-0157

PHYSICIAN FORM –NON PRESCRIPTION & PRESCRIPTION MEDICATIONS

New York State Law requires this form to be FILLED OUT BY A PHYSICIAN in order for our nurse to dispense medication to your child when needed.

Student's Name _____ **D.O.B.** _____ **Weight** _____

DRUG	ROUTE	DOSAGE	SCHEDULE	PROVIDER ORDER	COMMENTS
Tylenol/ Acetaminophen	PO (chewable tabs elixir or tablet)	Per label instructions by, age/weight	Prn Q 4 h for pain or Fever >_____	Yes No	
Ibuprofen	PO (Suspension or tablet)	Per label instructions by age/weight	Prn Q 6-8 h for pain or fever >_____	Yes No	
Antacid (Mylanta, Maalox, Tums)	PO (liquid or chewable)	Per label instructions age/weight	Prn As per label instructions	Yes No	
Diphenhydramine (Benadryl)	PO (Liquid or tablet)	Per label instructions by, age/weight	Prn As per label instructions	Yes No	
Bacitracin/ Neosporin Ointment	Apply to affected area TID	Per label instructions	Prn As per label instructions	Yes No	
Prescription					
Prescription					

Physicians Name: (please print) _____

PHYSICIANS SIGNATURE: (required) _____ Telephone # _____

Physicians Stamp: (required) _____ Date:_____

Parent Signature: (required) _____ Date:_____

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INDEPENDENT MEDICATION USE AND CARRY FORM
REQUIRED PROVIDER AND PARENT/GUARDIAN PERMISSIONS

Directions for health care provider: This form must be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently use and carry their medication as required by NYS law. **A provider order and parent / guardian permission is needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes**. These medications should be identified by checking the appropriate boxes below.

Student name:_____D.O.B. _____

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity with no supervision by school staff. This order applies to the medication(s) checked below:

The student is diagnosed with:

- ❑ Allergy and requires Epinephrine Auto-injector
- ❑ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ❑ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ❑ _____ which requires rapid administration of _____.
  (State Diagnosis) (Medication Name)

Signature:_____ Date:_____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may use and carry this medication at any school/school sponsored activity with no supervision by school staff.

Signature: _____ Date:_____

Please Return to School Nurse:

Suzanne Rota, RN, MSN	Roaring Brook Elementary School

Phone: (914) 238-7205 X 6104	Fax: (914) 817-0157	Email: surota@ccsd.ws