Horace Greeley High School
Health Office
70 Roaring Brook Road
Chappaqua, NY 10514

Kathy Brehm RN
914-238-7201 Ext. 2104
Fax 914-817-0123

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 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	
Medication:					
Medication:					

Health Care Provider Name: (print) _____ **Signature:** _____ **STAMP**

Parent's Signature: _____ **Date:**_____

*****FOR EPIPEN & ASTHMA INAHLER & DIABETES MEDS ONLY FILL OUT ATTESTATION BELOW***:**

OPTIONAL PERMISSIONS FOR INDEPENDENT MEDIATION CARRY AND USE AT SCHOOL

Health Care Provider Independent Carry and Use Permission: I attest that this student has demonstrated to me that they can self-administer this rescue medication affectively and may carry and use this medication independently at school with no supervision by school personnel.

Healthcare Provider Signature_____ **Date:**_____

Parent/Guardian Independent Carry and Use Permission (If Ordered by Provider Above): I agree my child can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Parent Signature_____ **Date:**_____