

CHAPPAQUA CENTRAL SCHOOL DISTRICT

MEDICATION PHYSICIAN AUTHORIZATION FORM

****New York State Law requires this form to be FILLED OUT BY A PHYSICIAN and signed by a parent in order for our nurses to dispense medication to your child when needed. Prescription meds must be in original labeled container brought in by a parent.

Student name: _____ D.O.B. _____ Weight: _____

DRUG NAME	ROUTE	DOSAGE	SCHEDULE	PROVIDER ORDER	COMMENTS
Prescription medication:					
Prescription medication:					
Prescription medication:					
Bacitracin/Neosporin Ointment	Apply to affected area TID	Per label instruction	PRN As per label instructions	Yes No	
Calamine	Apply to affected area TID	Per label instruction	PRN As per label instructions	Yes No	
Antacid (Tums)	PO liquid or chewable	Per label instruction	PRN As per label instructions	Yes No	
Diphenhydramine (Benadryl)	PO liquid or tablet	Per label instruction	PRN Q 6-8 hours for pain or fever > _____	Yes No	
Ibuprofen	PO liquid or tablet	Per label instructions	PRN Q 6-8 hours for pain or fever > _____	Yes No	
Tylenol/Acetaminophen	PO liquid or tablet	Per label instructions by age/weight	PRN Q 4 hours for pain or fever > _____	Yes No	

Healthcare Provider Name: _____
 (Print) (Signature)

STAMP

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

Douglas Grafflin:
Danielle Bonsignore
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