SFASD

INDIVIDUAL ORDER for SF OTC Medications

Student Name ______________________________ DOB ___________

School / Grade ______________________________ School Year ___________

In accordance with school policy, medication(s) should be given at home before and/or after school. However, when this is not possible, prior to receiving the medication at school, this form must be completed and signed by a parent and physician. A new form and signatures are required each school year. All medications below are available in the health suite.

Prescriber's Authorization for OTC Meds at school

Check medication permitted - complete dose appropriate for student - sign below.

Medication:	Dose:	Route:	Frequency:
☐ Acetaminophen	___________ mg	PO	q 4-6 hrs PRN
☐ Ibuprofen	___________ mg	PO	q 6-8 hrs PRN
☐ TUMS	___________ tab(s)	PO	q 4 hrs PRN

Prescriber's Signature ______________________________ Date ___________

Prescriber's Name/Title (print) ______________________________ Phone ___________

Parent / Guardian Authorization

I give my permission for my child, ____________________, to receive the above medication ordered by a licensed prescriber during the school day. I understand that the medications will be given by school health personnel according to my child's licensed prescriber's directions.

Parent/Guardian Signature ______________________________ Date ___________

Parent/Guardian Name (print) ______________________________ Phone ___________