THE HALLEN SCHOOL

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MEDICATION ORDER FORM

Student Name: _____ Date of Birth: _____/_____/_____

I give permission to The Hallen School Nurse, to administer medication as per the physician's orders below. I also give permission for the nurse to contact my child's physician concerning any medication issues that may arise.

_____ _____ _____
Parent/Guardian – Print Name Parent/Guardian- Signature Date

For Medical reasons, an RN is required to accompany this student on ALL field trips: YES or NO (Circle one)

PHYSICIAN ORDERS- OVER THE COUNTER MEDICATION

DRUG	ROUTE	DOSAGE	SCHEDULE	MD INITIALS	COMMENTS
Tylenol	*PO Tabs, Chewable, or Liquid*	*Per Label instructions by age/weight*	*Q 4 hr PRN for pain or fever* ➢ *100.0 F*		
Ibuprofen	*PO Tablet or Liquid*	*Per label instruction by age/weight*	*Q 6 hr PRN for pain or fever* ➢ *100.0 F*		
Benadryl	*PO Caplet/ Liquid*	*Per label instructions by age/weight*	*Q 6 hr PRN for allergic reaction (hives/insect bites)*		
TUMS	*PO Chewable*	*Per label instruction by age/weight*	*Q 6 hr PRN for upset stomach*		
Cough Drops	*PO: w/or Without menthol/Pectin*	*Per label instruction by age/weight*	*PRN for sore throat, cough, throat irritation*		
Eye Drops	*Please attach separate order*				

*****For all other medications, please attach a copy of the MD prescription to this form. All Asthma, Glucagon, and Epi-pen orders must have a separate form filled out by the physician.***

Physicians Signature: _____ Date: _____

MD STAMP REQUIRED: