

Saint David's School
12 East 89th Street • New York, NY 10128

2008-2009 OVER-THE-COUNTER (OTC) MEDICATION ORDERS

Return by July 31, 2008

Student's Name (print)

Date of Birth
September

Grade Entering in

Nurses practicing in the school setting are governed by New York Educational Law, Article 139-Nursing (Nurse Practice Act). All medications, including over-the-counter medications, given in school must be prescribed by a licensed health care provider on an individual basis as determined by the student's health status. Only a Registered Nurse may administer medication to students. All medications, other than the ones below, will require a separate prescription and protocol.

Over-the Counter Medication	Signs/Symptoms	Dose/Interval
Acetaminophen Form: Liquid/Pill/Chewable Route: PO	<input type="checkbox"/> Fever $\geq 100.0^{\circ}$ F <input type="checkbox"/> General <u>pain relief</u> associated with headache, tooth or orthodontics, sports injury	<input type="checkbox"/> Based on weight/age per package instructions <input type="checkbox"/> Other Dosage recommendation: _____ _____
Ibuprofen Form: Liquid/Pill Route: PO	<input type="checkbox"/> Fever $\geq 100.0^{\circ}$ F <input type="checkbox"/> General <u>pain relief</u> associated with headache, tooth or orthodontics, sports injury	<input type="checkbox"/> Based on weight/age per package instructions <input type="checkbox"/> Other Dosage recommendation: _____ _____
Calcium Carbonate (antacid) Form: Chewable Route: PO	<input type="checkbox"/> Indigestion	<input type="checkbox"/> 1-2 tablets chewed every 4 hours <input type="checkbox"/> Other Dosage recommendation: _____ _____
Cough drops Route: PO	<input type="checkbox"/> Cough <input type="checkbox"/> Sore throat	<input type="checkbox"/> Children 5 years and over: dissolve 1 drop in mouth. May repeat every 2 hours as needed.
Loratidine 10mg (24 hour) Form: Pill Route: PO	<input type="checkbox"/> Itchy, watery eyes <input type="checkbox"/> Sneezing	<input type="checkbox"/> Children 6 years and over: 1 tablet daily <input type="checkbox"/> Dosage recommendation: _____ _____
Diphenhydramine HCL Form: Liquid/Pill/Melt Route: PO	<input type="checkbox"/> Symptoms associated with Allergic Reaction: Hives, Rash, Anaphylaxis	<input type="checkbox"/> 12.5mg <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> Dosage recommendation _____

*This order form will be in effect for the 2008-2009 school year only. **These orders will **not be valid** without the **Provider's Office Stamp** below. Stamp should contain name, address, phone and license #. Parents must also sign. Parent signature implies permission for nurse to contact healthcare provider to discuss the medical needs of the student with regard to medication administration.*

****Office Stamp:**

Provider's Signature

Date Ordered (*Order will expire on the last day of 2008-2009 school year.)

Parent/Guardian's Name (print)

Parent/Guardian's Signature

Date