Northwest Asthma & Allergy Center, P.S.

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PHYSICIAN'S ORDERS FOR MEDICATION AT SCHOOL

Whenever possible, the parent and physician will design a schedule for giving medication outside of school hours. Medication is ordered to be given to a student at school only when necessary. Only prescription medication will be administered. Medication may be kept by the patient and self-administered upon physician authorization, or medication may be kept and administered by school nurse, principal or other designated personnel.

The school accepts no responsibility for untoward reactions when the medication is dispensed in accordance with the physician's directions.

❖	Name of patient:	
❖	Name of medicine:	*Benadryl / diphenhydramine*
	Diagnosis for which medication is given:	*Food Allergy; Urticaria (hives); Allergic Rhinitis (Allergies)*
	Form and dose:	*12.5mg/5 ml (elixir); 12.5 mg; 25 and 50 mg tablets/capsules*
	If medication to be given DAILY, at what time?	*As needed*
	If medicine is to be given "WHEN NEEDED," describe indications:	*For allergy symptoms: Nasal drainage, sneezing, hives*
	How soon can it be repeated?	*Up to every 4-6 hours*
❖	Patient ☐ may ☐ may not keep medications on person and self-administer.	
	Side effects of drug (if any) to be expected:	*Drowsiness, dizziness, dry mouth, nausea, irritability*
	Length of time this authorization is valid:	*1 year*
❖	Date:	Physician's Signature:

PARENT'S PERMISSION

I request that my child be allowed to take medication as described above. The medication is to be furnished by me in the original container labeled by the pharmacy or physician with the name of the medicine, the amount to be taken, and the time of day to be taken. The physician's name is on the label. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered in accordance with the physician's directions. This authorization is good for the current school year only. In case of necessity the school district may discontinue administration of the medication with proper advance notice. I am the parent or the legal guardian of the child named.

Date: ___________ Signature of parent or guardian: ______________________________

Student's home address: ______________________________

Emergency daytime phone: ____________________ School: ______________________

F:Nurse/Patient/Schoolbenedryl-2003