Bala Cynwyd
School for Young Children

PHYSICIAN'S STANDING ORDERS FOR ADMINISTERING OVER THE COUNTER MEDICATIONS

1. MEDICATION/PHYSICIAN AUTHORIZATION

_____ / _____
Child's Name ***D.O.B.***

is a patient in our practice. She/He may be given the following over-the-counter medications, if needed during the school day, when directed by his/her parents, and when indicated by the symptoms below, according to the dose schedule and instructions provided by the manufacturer of the medication:

APPROVED MEDICATIONS:

1. _____ Acetaminophen (Tylenol, etc.)
oral suspension or infant drops
For the following symptoms:

_____

2. _____ Ibuprofen (Advil, Motrin, etc.) oral suspension or infant drops
For the following symptoms:

_____

3. _____ Benadryl elixir
For the following symptoms:

_____

4. _____ Other: _____
name of medication
For the following symptoms, with dosage as indicated below:

_____

_____ _____ _____
Physician Signature **Print Physician Name** **Date**

Please call _____ with any questions.
Physician Telephone Number

2. PARENT AUTHORIZATION

I authorize the Staff of the Bala Cynwyd School for Young Children and my child's health professional to communicate directly, if needed, to clarify information on this Form.

_____ _____
Parent Signature **Date**