

HARRISVILLE CENTRAL SCHOOL
 14371 PIRATE LANE
 HARRISVILLE, NY 13648
 PHONE (315)543-2707 FAX (315)543-2360

**2021-2022
 NURSE MEDICATION DISPENSING FORM**

New York State Education Department requires the school to have on file permission signed by the parent/guardian and the child's physician **before** we can administer **any** medication to your child. This includes both prescription and non-prescription (over the counter) medications. After consultation with the school physician, the following non-prescription medications will be available in our Health Office for use by the school nurse.

Please mark an **X** to the left of any medication you **DO NOT** wish your child to receive.

<input type="checkbox"/>	Acetaminophen	For age every 4 or 6 hours as needed for mild aches, pain, headache, toothache, menstrual cramps, fever
<input type="checkbox"/>	Bacitracin	Antibiotic ointment for abrasions & superficial wounds
<input type="checkbox"/>	Benadryl	12.5 mg by mouth when needed for Allergic Reaction
<input type="checkbox"/>	Chloroseptic Spray	Sore throats, mouth pain
<input type="checkbox"/>	Cough Drops/Lozenges	Soothes throat, aids in preventing cough
<input type="checkbox"/>	Cramergesic	Muscle rub, like Bengay
<input type="checkbox"/>	Foille Burn	Ointment or spray: soothes minor burns or sunburn
<input type="checkbox"/>	Hydrocort Cream	To stop the itch of bites and rashes
<input type="checkbox"/>	Ibuprofen	For age every 4 or 6 hours as needed for headache, , musculoskeletal complaints, menstrual cramps
<input type="checkbox"/>	Murine Tears	Lubricant eye drops, dry eyes
<input type="checkbox"/>	Ora-Jel	Toothache, mouth sores
<input type="checkbox"/>	Topical Sunscreen	To Protect against overexposure to sun
<input type="checkbox"/>	Vaseline	To lubricate chapped lips
<input type="checkbox"/>	Insect Repellent	No DEET.
<input type="checkbox"/>	Waterless Hand Sanitizer	To cleanse hands when soap & water are not available
<input type="checkbox"/>	Other	Explain:
<input type="checkbox"/>		

I give permission for the use of all of the above medications in the treatment of my child **EXCEPT THE ONES THAT ARE MARKED WITH AN X**, as deemed appropriate by the school nurse. This permission will remain in effect for the 2020-2021 school year unless I notify the school in writing.

STUDENT NAME _____ DATE OF BIRTH _____

BOTH
SIGNATURES
ARE
REQUIRED

 PARENT/GUARDIAN SIGNATURE

 DATE

 PHYSICIAN'S SIGNATURE

 DATE

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Permission for Prescription Medication in School

It is necessary for the school nurse to receive a written order from a medical practitioner if a child is to be given a prescription medication during the 2021 - 2022 school year.

If your physician has advised you this medication needs to be administered to your child during school hours, please have this form completed by your doctor and returned to the health office, with the medication. The medication needs to be delivered by a parent and be in a prescription labeled container.

Students name: _____ Date of Birth: _____

Diagnosis: _____

Please give:

Prescribed Medication _____
Dosage _____
Route _____
Time(s) Medication Must Be Given _____
Duration _____
Adverse Reaction(s) _____

Date _____ Physician's Signature _____ Phone #: _____

I, the undersigned, hereby give permission for the school nurse to give my child the medication prescribed above.

Date _____ Parent's Signature _____

Inhaler Self-Medication Release

If the above medication is an inhaler and the child named is in 6-12 and has been instructed on the inhaler's proper use, your signature below gives him/her permission to carry the inhaler on his/her person, or to keep it in his/her locker as needed.

Date: _____ Parent's Signature: _____