OVER-THE-COUNTER MEDICATION FORM

The Charles Finney School Health Office

2070 Five Mile Line Road
Penfield NY 14526

ORDERS FOR: _____ DOB_____ WEIGHT_____

Medication/Food Allergies: _____

If you wish your child to receive **A<u>NY</u>** medication at school, the **New York State regulation requires written permission from your health care provider and parent**. This includes all over-the-counter medications. This written permission must be renewed annually.

If you wish your child to have a **specific** over the counter medication, not carried in the Charles Finney Health Office, please provide that medication in a new unopened bottle with your child's name**.** Administration of over-the-counter medications will be "per label" directions for age/weight unless otherwise indicated by the provider.

Circle YES/NO indicating which medications are authorized:

Drug Name	Authorized	Drug Name	Authorized
Acetaminophen (fever/discomfort)	YES/NO	Midol (Menstrual Cramps)	YES/NO
Bacitracin (antibiotic ointment)	YES/NO	Throat Lozenges (throat irritation)	YES/NO
Benadryl (allergies) or generic	YES/NO	Tums (heartburn, stomach upset)	YES/NO
Cortisone Cream (topical) for skin irritation	YES/NO	Visine (regular and allergy) for eye irritation	YES/NO
Cough Drops	YES/NO	Other:	YES/NO
Ibuprofen (fever/discomfort)	YES/NO	Other:	YES/NO

Health Care Provider Permission for Independent Use and Carry (*<u>Middle & High School ONLY)</u>*

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school-sponsored activity. Staff intervention and support is needed only during an emergency.

YES_____ NO_____

<u>PARENT/GUARDIAN AUTHORIZATION REQUIRED</u>

Signature: _____

Phone Number: _____

Date: _____

<u>PHYSICIANS AUTHORIZATION REQUIRED</u>

Signature: _____

Phone Number: _____

Date: _____