East Rochester Union Free School District

OVER-THE-COUNTER/PRESCRIPION MEDICATION FORM

(Parent and Prescriber's Authorization for Administration of Medication in School)

For Grades 9-12 **Fax: 248-6336**

ORDERS FOR:_____

Name DOB WT

Medication/Food Allergies_____

If you wish your child to receive **ANY** medication at school the **New York State regulation requires written permission from your health care provider and parent**. This includes all prescriptions and/or over-the-counter medications. This written permission must be renewed annually. **All non-prescription medications MUST be in new un-opened bottles. Prescription medications must have actual prescription labels on them, as well as Epi-pens and Inhalers with the sticker on them for safety reasons**. Administration of over-the-counter medications will be "per label" directions for age/weight unless otherwise indicated by provider.

Drug Name	Provider Order	Drug Name	Provider Order
Acetominophen(fever/discomfort)	Yes/No	Milk of Magnesia(constipation)	Yes/No
Benadryl (allergies) or generic	Yes/No	Mylanta (stomach upset)	Yes/No
Cortizone Cream(topical) for skin irritation	Yes/No	Pepto Bismol (nausea, unsettled stomach)	Yes/No
Cough Drops	Yes/No	Tums (heartburn,stomach upset)	Yes/No
Ibuprofen (fever/discomfort)	Yes/No	Eye drops	Yes/No
Imodium (diarrhea) or generic	Yes/No	Midol (menstral cramps)	Yes/No

Prescripton Medication To Be Given in School

Drug Name	*Dose*	*Directions*	*Reason*

I assess this child ☐ to be self directed and may self carry: ☐ Epi-Pen ☐ Inhaler

ALL MEDICATION MUST BE PROVIDED BY PARENT

Parent/Guardian Authorization Required

Signature_____

Phone Number:_____

Date:_____

Doctor's Authorization Required

Signature:_____

Phone Number:_____

Date:_____