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.

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

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