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

2025 - 2026

NURSE MEDICATION DISPENSING FORM

New York State Education Department requires each school to have a medication permission form signed by the parent/guardian and the child's physician **before** the nurse 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.

	Acetaminophen	For age every 4 or 6 hours as needed for mild aches, pain, headache, toothache, menstrual cramps
	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
	Foille Burn	Ointment or spray: sooths minor burns or sunburn
	Ibuprofen	For age every 4 or 6 hours as needed for headache, , musculoskeletal complaints, menstrual cramps
	Ora-Jel	Toothache, mouth sores
	Vaseline	To lubricate chapped lips
	Insect Repellent	No DEET.
	Waterless Hand Sanitizer	To cleanse hands when soap & water are not available

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 2025- 2026 school year unless I notify the school in writing.

STUDENT NAME _____ DATE OF BIRTH _____

Parent & Physician's SIGNATURES REQUIRED

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

Roger Mundo, MD 6/6/25
PHYSICIAN'S SIGNATURE DATE

HARRISVILLE CENTRAL SCHOOL
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 school day.

If your physician has advised you or if you feel your physician wants this medication to be administered to your child during school hours, please have this form completed and returned to the health office, with the medication. The medication should be accompanied by a parent and be in prescription labeled container.

Student 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 grades 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 to use as needed.

Parent's Signature _____Date _____