

**BERLIN CENTRAL SCHOOL
MEDICATION CONSENT FORM**

To be completed and signed by student's Licensed Health Care Provider
(New York State law requires that all medication orders for students be patient specific)

Section I: Indicate approval/disapproval of the following over the counter medications & treatments for use at school. **The school will stock these medications if approved.**

Medication Name	Dosage & Indication For Use	Physician Approval	Physician Disapproval	Concerns/Comments
Acetaminophen (Tylenol)	Per label instructions Per age/wt.	Yes ____	No ____	
Ibuprofen (Motrin)	Per label instructions Per age/wt.	Yes ____	No ____	
Bacitracin (Antibiotic) Ointment	Per Label Instructions	Yes ____	No ____	
Burn Ointment	Per Label Instructions	Yes ____	No ____	
Caladryl (Anti-itch) Lotion	Per Label Instructions	Yes ____	No ____	
Benzalkonium (Antiseptic) Solution	Per Label Instructions	Yes ____	No ____	
Medicaine (Insect Bite) Swabs	Per Label Instructions	Yes ____	No ____	
Orajel (Toothache)	Per Label Instructions	Yes ____	No ____	
Sunscreen/Sunburn	Per Label Instructions	Yes ____	No ____	
Benadryl (Diphenhydramine HCL)	Per Label Instructions	Yes ____	No ____	
Cough Drops	Per Label Instructions	Yes ____	No ____	
Dramamine (Motion Sickness)	Per label instructions Per age/wt.	Yes ____	No ____	Overnight Field Trip Use Only
Peptobismol (Stomach Relief)	Per label instructions Per age/wt.	Yes ____	No ____	Overnight Field Trip Use Only

Section II: Please list student's use of prescription and/or non-prescription medications and indicate the need for use at school. **Parents are responsible for providing these medications.**

Medication	Route	Dosage	Frequency/Indications	Comments	Use at School
					Yes/No
					Yes/No
					Yes/No

Section III: Please indicate if the student is self-directed and may carry their medication.

Yes (Student **is** self-directed) No (student **is not** self-directed)

Section IV: Please provide the appropriate signatures and return to Health Office.

Licensed Provider's Name: _____ Phone Number: _____

Licensed Provider's Signature: _____ Date: _____

Student's Name: _____ Parent Signature: _____ Date: _____