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 _____	
Tums (Stomach Relief)	Per label instructions Per age/wt.	Yes ____	No _____	

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: For Epi pens, Inhalers and Diabetic supplies only. Please indicate if the student is self-directed and may carry their medication. Self-carry does **NOT** apply to Tylenol, Ibuprofen, cough drops, or other over the counter medications..

☐ 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: _____

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