MANLIUS PEBBLE HILL SCHOOL
5300 Jamesville Rd., Syracuse, NY 13214
Phone: 315-446-2452 Health Office fax: 1-866-846-0684

MEDICATION PERMISSION FORM
2017-2018

This form is required for all students, and must be submitted to the MPH Health Office by the first day of school (or within 10 days of enrollment for students registering after the first day of school). Forms must be signed by a parent and a New York State Health Care Provider (HCP).

____ ________________ ______/_____/_____

(Last Name) **(First Name)** **(Grade in 2017-2018)** **(Date of birth)**

New York State law requires that all students who are to be given prescription or non-prescription medications in school have a consent form on file in the Health Office. Medications must be delivered to the school nurse by an adult in their original containers. At no time should students be carrying medications except authorized rescue medications with appropriate permission signed. The following medications are available in the Health Office. Please check the boxes of those medications (and fill in the dosage) you wish your child to receive from the nurse at her discretion.

Acetaminophen (for headache, pain, menstrual cramps or fever]
- ☐ Extra Strength Tablet (500 mg) ____________ every ____ hours
- ☐ Regular Strength Tablet (325 mg) ____________ every ____ hours
- ☐ Children's Chewable (80 mg) ____________ every ____ hours

Ibuprofen [for headache, pain, menstrual cramps or fever]
- ☐ Tablets (200 mg) ____________ every ____ hours
- ☐ Children's Chewable (100 mg) ____________ every ____ hours

Benadryl: Diphenhydramine [for allergic reactions]
- ☐ Elixir (12.5 mg/tsp) ____________ every ____ hours
- ☐ Tablets 25 mg. ________________every ________hours

Topical (applied after local cleansing with soap and water]
- ☐ Calamine Lotion, Aloe Vera ointment (insect bites, dry eczema, hives, dry itchy red rashes)
- ☐ Antibiotic Ointment (minor scrapes, abrasions, burns)
- ☐ Insect sting swab

Cough/ Sore Throat Lozenges
- ☐ _________ lozenge(s) every ______ hours

OTHER (must be provided directly to the Health Office with an accompanying doctor's order confirming medication name, dose, time to be given, route, & reason).
- ☐ ____
- ☐ ____
- ☐ ____

☐ **Please check here if you do not want your child to receive any medication in the MPH Health Office**.

_______ ____

Parental Signature   Daytime phone #   Date

____

Signature of New York State licensed Healthcare Provider (MD, DDS, NP, PA)   Office phone #Date