



MANLIUS PEBBLE HILL SCHOOL  
 5300 Jamesville Road, Syracuse, NY 13214  
 Phone: 315-446-2452 | Health Office Fax: 1-866-846-0684

## MEDICATION PERMISSION FORM 2021-2022

This form is required for students to receive medications in the MPH Health Office. Forms must be signed by a parent and a Health Care Provider (HCP) licensed in New York State.

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 (Last Name) (First Name) (Grade in 2021-2022) (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 their discretion.

**Acetaminophen** (for headache, pain, menstrual cramps, or fever]

- 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).
- Clear Anti-Itch Lotion (insect bites, dry eczema, hives, dry itchy red rashes).
- Antibiotic Ointment (minor scrapes, abrasions, burns)
- Insect sting swab

**Cough/Sore Throat Lozenges**

- \_\_\_\_\_ lozenge every \_\_\_\_ hours

**OTHER** (Medications must be provided directly to the Health Office. Please include medication name, dose, time to be given, route, & reason).

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_  
**Parental Signature** Daytime phone # Date

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