

*Sherburne-Earlville Central School  
Health Office*

*Phone: Elementary 607-674-7389 Fax # 607-674-8440*

*Phone MS/HS: 607-674-7314 Fax # 607-674-7383*

**The following section is to be completed by the Parent/Guardian**

**Student Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Grade** \_\_\_\_\_

**Health Care Provider's Name** \_\_\_\_\_

**Address & Telephone Number** \_\_\_\_\_

I request that my child be assisted in taking the medication(s) described below at school by the authorized person(s).

**The medication is to be furnished in a properly labeled original container from the pharmacy.**

**\*Parent/Guardian Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Home Phone** \_\_\_\_\_

**Emergency Number** \_\_\_\_\_

**The following section is to be completed by the Health Care Provider – Only**

**Name of Medication** \_\_\_\_\_

**Dose** \_\_\_\_\_ **Frequency** \_\_\_\_\_ **Time** \_\_\_\_\_

**Diagnosis for which medication is given** \_\_\_\_\_

**List significant side effects** \_\_\_\_\_

**Length of time this treatment is recommended (current school year)** \_\_\_\_\_

**Other Information** \_\_\_\_\_

**Is child authorized to self-medicate? (Inhaler or Bee Sting Kit ONLY)** \_\_\_\_\_

**Student may self-medicate and carry medication?** \_\_\_\_\_yes \_\_\_\_\_no

☐ **I attest that this student has demonstrated to me that they can self-administer the medication(s) listed above safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school-sponsored activity with no supervision by school staff.**

**\* Health Provider's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Sherburne-Earlville Middle/High School  
Health Office



Phone: 607-674-7310/7314

Fax: 607-674-7383

***The following section is to be completed by the Parent/Guardian***

***Student Name*** \_\_\_\_\_ ***DOB*** \_\_\_\_\_ ***Grade*** \_\_\_\_\_

***Sherburne-Earlville School-Based Health Center Provider:*** \_\_\_\_\_  
(Print name)

***Address & Telephone Number:*** Sherburne-Earlville School Based Health Center, Sherburne, NY, 607-674-8416

I request that my child be assisted in taking the medication(s) described below at school by the authorized person(s).  
**The medication is to be furnished in a properly labeled original container from the pharmacy.**

\_\_\_\_\_  
***\* Parent/Guardian Signature***      ***Date***      ***Home Phone***      ***Emergency Number***

***The following section is to be completed The School-Based Health Center Health Care Provider***

***Name of Medication:***      Tylenol 325mg., 1- 2 tabs      Ibuprofen 200mg., 1 -2 tabs

***Frequency:***      every 6 hours      ***Time:***      as needed

If the medication is to be given "when needed," describe criteria:

Headache, Menstrual cramps, Fever, Orthodontic discomfort, toothache, pain or

***List significant side effects:*** Not applicable or: \_\_\_\_\_

***Expiration of order*** \_\_\_\_\_

***If student has more than 3 headaches in 1 week, please refer to SBHC for evaluation***

\_\_\_\_\_  
***\* Health Care Provider's Signature***

***Date***