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 in 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 <u>Parent/Guardian</u>

Student Name _____ DOB _____ Grade ____

<u>Sherburne-Earlville School-Based Health Center Provider:</u> _____
(Print name)

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

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 <u>The School-Based Health Center Health Care Provider</u>

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

Frequency: **<u>every 6 hours</u>** *<u>Time</u>*: **<u>as needed</u>**

If the medication is to be given "*<u>when needed,"</u>* describe criteria*:*

<u>Headache, Menstrual cramps, Fever, Orthodontic discomfort, toothache, pain or</u> _____

_____

List significant side effects: **Not applicable** *or:* _____

Expiration of order _____

<u>If student has more than 3 headaches in 1 week, please refer to SBHC for evaluation</u>

_____

**** Health Care Provider's Signature*** ***Date***