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 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***

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 by the School-Based Health Center (SBHC)

Name of Medication: _____

Frequency: _____ *Time*: _____

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

_____

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

Student may carry medication and self-medicate? _____ ***yes*** _____ ***no***

Expiration of order _____

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

Other Information _____

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