Central Baptist Christian Academy

A Ministry of Central Baptist Church
1606 NY RT 12 Binghamton, NY 13901
(607) 648-6210

MEDICATION REQUEST FORM

Student's Name: _____Age _____Grade: _____

When your child's physician feels that medication is necessary during the school day, you are asked to follow certain procedures. School Nurses **cannot** administer medication to students without a written order from a physician. Therefore, you are requested to provide:

1. A written note from you, the parent or guardian.
2. A written order from your physician or other health care provider.
3. A new physician's order for each new medication or any change in medication dosage.
4. A new medication order at the beginning of each school year.
5. **Bring medication to school in the prescription bottle or original packaging** if it is an over-the-counter medication.

Medication should not be out-dated before the end of the school year. Students are **not** allowed to carry any medication of any kind on their person, whether over the counter or prescription. These medications should be turned into the school office. If your child **needs** to carry a prescription medication please call the school.

Please check the medications that you, the parent and the physician approve that the school's appropriate personnel may administer to your child this school year.

_____ For joint and muscle pain/injury, menstrual cramps, headache or pain:
Advil/Ibuprofen 200mg 1-2 tablets every 4-6 hours as needed.
_____ For joint and muscle pain/injury, menstrual cramps, headache or pain:
Tylenol/Acetaminophen 500mg 1-2 tablets every 4-6 hours as needed.
_____ *Grades pre-K-3rd* Children's or Jr. Strength Tylenol according to age for pain, fever, or injury.
_____ *Grades pre-K-3rd* Children's Motrin/Ibuprofen according to age for pain, fever, or injury.
_____ Cough drops for sore throat, per package directions as needed.
_____ Tums/Antacid tablets for stomach ache per package directions as needed.
_____ Eye Wash/Saline Solution for eyes that need to be flushed per package directions as needed.
_____ Other medications as listed:
_____

Please list any allergies:
_____

I request that my child, _____, receive the medication as listed above and prescribed by the health care provider. **He/she has been instructed in, and understands, the purpose and appropriate method and frequency of use of these medications.**

I understand that the school nurse, or other designated person will administer the medication. This authorization shall be for the **2021-2022 school year** and shall remain in effect until the school receives written revocation of this authorization.

This form must be signed by your licensed health care provider in addition to parent/guardian.

Parent signature: _____ Licensed Health Care Provider: _____