BERLIN CENTRAL SCHOOL
MEDICATION CONSENT FORM

To be completed and signed by student's Licensed Health Care Provider

(New York State law requires that all medication orders for students be patient specific)

Section I: Indicate approval/disapproval of the following over the counter medications & treatments for use at school. **The school will stock these medications if approved.**

Medication Name	Dosage & Indication For Use	Physician Approval	Physician Disapproval	Concerns/ Comments
Acetaminophen (Tylenol)	Per label instructions Per age/wt.	Yes ____	No _____	
Ibuprofen (Motrin)	Per label instructions Per age/wt.	Yes ____	No _____	
Bacitracin (Antibiotic) Ointment	Per Label Instructions	Yes ____	No _____	
Burn Ointment	Per Label Instructions	Yes ____	No _____	
Caladryl (Anti-itch) Lotion	Per Label Instructions	Yes ____	No _____	
Benzalkonium (Antiseptic) Solution	Per Label Instructions	Yes ____	No _____	
Medicaine (Insect Bite) Swabs	Per Label Instructions	Yes ____	No _____	
Orajel (Toothache)	Per Label Instructions	Yes ____	No _____	
Sunscreen/Sunburn	Per Label Instructions	Yes ____	No _____	
Benedryl (Diphenhydramine HCL)	Per Label Instructions	Yes ____	No _____	
Cough Drops	Per Label Instructions	Yes ____	No _____	MS/HS Only
Dramamine (Motion Sickness)	Per label instructions Per age/wt.	Yes ____	No _____	Overnight Field Trip Use Only
Peptobismol (Stomach Relief)	Per label instructions Per age/wt.	Yes ____	No _____	Overnight Field Trip Use Only

Section II: Please list student's use of prescription and/or non-prescription medications and indicate the need for use at school. **Parents are responsible for providing these medications**.

Medication	Route	Dosage	Frequency/Indications	Comments	Use at School
					Yes/No
					Yes/No
					Yes/No

Section III: Please indicate if the student is self-directed and may carry their medication.

☐ Yes (Student **is** self-directed) ☐ No (student **is not** self-directed)

Section IV: Please provide the appropriate signatures and return to Health Office.

Licensed Provider's Name: ___________________________ Phone Number: _________________

Licensed Provider's Signature: ________________________ Date: __________________________

Student's Name: _________________ Parent Signature: ______________________ Date: ________

Berlin MS/HS Health Office Phone Number – (518) 658-2515 ext. 224 Fax – (518) 658-0483