P.O. Box AA• 70 CHURCH STREET• MILLBROOK, NEW YORK 12545

Dear Parent/Guardian,

New York State Education Law has requirements for students and medication in school. **Both** a written order from a licensed provider and written parental permission are necessary for **any** medication given in school and/or during school activities. This includes Over-the-counter topical first aid applications such as **calamine lotion, vaseline, antibiotic ointment, antiseptic wash, etc.** and prescribed medications such as Epi Pens, inhalers, insulin etc. **This permission must be renewed on an annual basis.**

If you would like your child to have access to Over-the-counter topical treatments or if they will require any other medication during the school year, please have your licensed provider complete the provider section on the **Authorization for Medication** forms attached to this letter. In addition, please complete the corresponding parent/guardian permission section on the **Authorization for Medication** forms.

The medication should be delivered by a responsible adult (not the student) to the Health Office in a properly labeled, original container. Most pharmacists will divide prescription medication into two containers if you request this. Over-the-counter medications must be in the original manufacturer' s container with the student's name affixed to the container. All medications must be picked up at the end of the school year.

If your child needs to carry and administer his/her own medication at school and school activities then the licensed provider must attest that your child has demonstrated capability to **Independent Carry and Self-Administer** on the medication form. The category **Self-Administer with Staff Supervision** allows students to administer his or her own medication, under the direction of an unlicensed staff member, at school or school activities such as sports practice and field trips without the presence of a school nurse.

Incomplete forms will not be accepted. If you have any questions or concerns please contact your child's school nurse. Thank you for your attention to this matter.

Sincerely,

School Nurses
Millbrook Central School District

Revised-June 2021

P.O. Box AA • Millbrook, New York 12545

Superintendent of Schools	**845-677-4200**	**Elm Drive Elementary**	**845-677-4225**
Business Administrator	**845-677-4201**	**Alden Place Elementary**	**845-677-4220**
Pupil Personnel Services	**845-677-4215**	**Millbrook Middle School**	**845-677-4210**
District Clerk	**845-677-4200**	**Millbrook High School**	**845-677-2510**

AUTHORIZATION FOR OVER-THE-COUNTER TREATMENT

If you would like your child to have access to anything noted below New York State requires that both a physician and parent sign this form.

Student Name____ Grade___________
(Please Print) Last First

Please administer, as needed, the following over the counter medications throughout the school year to the above mentioned student as directed below:

Tylenol for headache, pain or low-grade fever
Ibuprofen for headache, pain or low grade fever
Calamine lotion or Hydrocortisone cream for itchy rash, insect bite
Benadryl for allergic reactions
Burn-Jel for minor burns
Antiseptic spray, Antibiotic ointment for lacerations or abrasions
Sting relief swab for bee stings and insect bites
Vaseline for chapped lips or dry skin
Eye lubricant, eye wash or saline solution for irritated eyes due to allergies or contacts

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❖ Please cross off anything you are not comfortable with and add anything else you feel your child may need (The above list is stocked by each school. Any other medication will have to be provided by you in the original container and brought to school by an adult).
❖ Generic forms may be used.
❖ Unless otherwise noted, all of the above will be administered as per label instructions.

Physician's Signature____

Physician's Phone Number _________________________Date_____________________

I request that the Health Office personnel administer the above medication to my child as prescribed by their physician.

Parent Signature____

Parent Name (please print)____

Millbrook CENTRAL SCHOOL DISTRICT

AUTHORIZATION FOR MEDICATION

In School and School Activities

Part 1 – (To Be Completed by Provider)

Student Name ________________________________ DOB ____________ Grade _________

Diagnosis ____

Provider: Please check one box. By checking the Independent Carry & Administer box you are attesting that you have determined the student is able to carry the medication responsibly and self-administer the medication effectively without any supervision.

Medication	Dose	Route	Time	[ ] please check one box
				[ ] Nurse or Parent Designee Must Administer [ ] Self Administer with Staff Supervision [ ] Independent Carry & Self Administer
				[ ] Nurse or Parent Designee Must Administer [ ] Self Administer with Staff Supervision [ ] Independent Carry & Self Administer
				[ ] Nurse or Parent Designee Must Administer [ ] Self Administer with Staff Supervision [ ] Independent Carry & Self Administer

Provider Name ____________________________________ Phone ____________________

Provider Address ____

Provider Signature _____________________________

Date ______________________________________

Part 2 – (To Be Completed by Parent or Guardian)

Check box and sign **only one** of the following options:

[ ] With Nurse or Designee Administer Permission
I request for my child to be given the medication prescribed above. I will provide the medication in the original pharmacy or over-the-counter container.

Parent/Guardian Signature ________________________________ Date _______________

[ ] With Self Administer with Supervision Permission
I agree that my child may self-administer the medication prescribed above with supervision from school staff. I will provide the medication in the original pharmacy or over-the-counter container.

Parent/Guardian Signature ________________________________ Date _______________

[ ] With Independent Carry & Administer Permission
I agree that my child can independently carry and administer the medication prescribed above without any supervision from school staff.

Parent/Guardian Signature ________________________________ Date _______________