Sunscreen & Insect Repellent Permission

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN *(please check those that apply)*

Student's Name _____**Date of Birth** _____

☐ Medication**: Sunscreen** **Product Name**:_____ **Route** Topical

Dose: 1 Application. Apply liberally to all exposed skin 30 minutes before sun exposure. Reapply after swimming or excessive sweating. Avoid eye area when applying to the face. Avoid contact with the eyes. Use cautiously or avoid use on irritated skin.
Purpose: Protect the skin from the sun preventing sunburn, premature aging, and reduce the risk of skin cancer.
Side Effects: If sunscreen causes redness or a rash, discontinue use.
All medications should be given as close to the prescribed time as possible; however, may be given up to one hour before and no later than one hour after the prescribed time. Please advise the school if there is a time-specific concern regarding administration of the medication.

☐ Medication**: Insect Repellent** **Product Name**: _____ **Route** Topical

Dose: 1 Application. Avoid eyes. Use cautiously or avoid use on irritated skin.
Purpose: Protect the skin from biting, stinging insects.
Side Effects: Skin irritation, rash. If redness or a rash noticed, discontinue use.
All medications should be given as close to the prescribed time as possible; however, may be given up to one hour before and no later than one hour after the prescribed time. Please advise the school if there is a time-specific concern regarding administration of the medication.

Physician's Signature _____ **Date** _____

Physician's Name (Please Print) _____ **Phone** _____

I give permission for the school nurse to share information with physician regarding this medication.

Parent's Signature _____ **Date** _____

Permission for Students to Carry Medication

A student may self-carry if:

1. The student is in grades 6-12. An exception to this rule is when the medication Lactaid, which younger students could carry.
2. The medication is **not:** a controlled substance, psychotropic, for ADHD, or contains dextromethorphan (DMX) or stimulant decongestants.
3. An assessment by the school nurse confirms that the student is self-directed to carry and self-administer her/his medication properly.
4. Parent assumes responsibility for insuring that his/ her child is carrying and taking the medication as ordered.

I give permission for this student to self-carry and self-administer the above medication as I consider her/him responsible. He/She has been instructed in and understands the purpose and appropriate method and frequency of administration of this medication.

_____ _____
Physician's Signature **Date**

I agree/assume responsibility that my child can use their medication independently at any school or sponsored activity

_____ _____
Parent's Signature **Date**

***** A licensed prescriber is required for all medications including all over the counter (OTC) and prescription medications.
***** A **non-parent** licensed prescriber is required for all controlled medication

This form may be returned electronically to SPED_ESY@pittsford.monroe.edu