



# Victor Central School Health Offices

**BOTH PARENT AND HEALTH CARE PROVIDER SIGNATURES ARE REQUIRED. THANK YOU**

Dear Parents and Guardians,

Whenever possible, the district asks that all medications, prescription, and non-prescription, be given at home. For medicines given in school, the State Education Department requires that physicians write a prescription for prescribed **AND** over-the-counter (OTC) medicines. Therefore, **a private health care provider note is required**, along with your written permission to have these products available to your child in school.

**Please understand that if you do not sign this permission slip and also have your child's Health Care Provider sign this permission slip, the school nurse will be unable to give your child these potentially soothing products.**

If you have any questions, please contact your child's building health office.

(585) 924-3252

*\*Parents/Guardians please sign below and have the child's Provider sign and return to the Health Office.  
\*Providers please indicate dosing instructions as listed below.*

Child's name \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade \_\_\_\_\_

I permit the school nurse to administer per the manufacturer's instructions and as appropriate the following OTC products **only as indicated** for my child for the **2025-2026** school year:

- |  |            |           |
|--|------------|-----------|
| Vaseline/Aquaphor topical for chapped lips or skin.....                            | Yes        | No        |
| Hypoallergenic Lotion topical for dry or irritated skin.....                       | Yes        | No        |
| Aloe topical for dry or irritated skin or burn.....                                | Yes        | No        |
| Calamine lotion or Benadryl Cream topical for itchy rash or insect bite.....       | Yes        | No        |
| Ophthalmic saline for contact lenses (if needed).....                              | Yes        | No        |
| Artificial Tears 1-2 drops OD for irritated and dry eyes.....                      | Yes        | No        |
| Neosporin ointment topical for minor skin cut, abrasion or wound.....              | Yes        | No        |
| Acetaminophen ___mg as needed PO every 6 hrs for Headache or menstrual cramps..... | Yes        | No        |
| Ibuprofen ___mg as needed PO every 6 hrs for Headache or menstrual cramps.....     | Yes        | No        |
| Tums ___mg as needed PO for indigestion.....                                       | Yes        | No        |
| Salt water gargles for sore throat or rinses for mouth sore.....                   | Yes        | No        |
| Cough drops PO as needed for sore throat/cough.....                                | Yes        | No        |
| <b>ALL OF THE ABOVE.....</b>   | <b>YES</b> | <b>NO</b> |

**NOTE: BOTH PARENT AND HEALTHCARE PROVIDER SIGNATURES ARE REQUIRED.**

X \_\_\_\_\_  
Parent Signature \_\_\_\_\_ Date \_\_\_\_\_ Daytime phone \_\_\_\_\_

X \_\_\_\_\_  
Health Care Provider Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone Number \_\_\_\_\_