



Bolivar-Richburg Central School District

Secondary Building (6-12), 100 School Street, Bolivar, NY 14715
Elementary Building (Pre-K-5), P.O. Box 158, 211 Main Street, Richburg, NY 14774
Pre-Kindergarten Building, 422 Main Street, Bolivar, NY 14715
Telephone: 585-928-2561

"The foundation of every nation is the education of its youth." ~ Diogenes

Over-The-Counter Medication Permission Form

Student Name **(Required):** _____ Date of Birth **(Required):** _____

In order for your child to receive stock over-the-counter medication during the school day, after-school, and on field trips (including overnight trips), **this form must be completed and signed by both a parent/guardian and the child's health care provider. This form must be updated each school year. The provider must be licensed to practice in New York State or a bordering state.**

This form is only for the medications listed below and will only be administered per provider direction. Only the school nurse can administer medications.

Select all options below:

- _____ Acetaminophen (Tylenol) Dose/frequency: _____
- _____ Ibuprofen (Advil) Dose/frequency: _____
- _____ Antihistamine (Benadryl, Zyrtec, Claritin, Allegra) Dose/frequency: _____
- _____ Antacid (students over 12 years old) Dose/frequency: _____
- _____ Burn gel with Lidocaine HCl Dose/frequency: _____
- _____ Antibiotic Ointment Dose: _____ Dose/frequency: _____
- _____ Hydrocortisone Cream Dose/frequency: _____
- _____ Sunscreen (parent must provide) Dose/frequency: _____

****BOTH PARENT/GUARDIAN AND PROVIDER SIGNATURES ARE REQUIRED****

Parent/Guardian: I give permission for the school nurse to dispense the medications listed above:

Parent/Guardian Name: _____

Signature: _____ Date: _____

Provider: I give permission for the school nurse to dispense the medications listed above:

Provider signature: _____ Date: _____