



EDGEMONT JR/SR. HIGH SCHOOL HEALTH OFFICE

200 White Oak Lane

Scarsdale, NY 10583

(914) 725-6175 - FAX: (914) 725-4032

In order to comply with **New York State Education Law**, the following steps must be taken if your child requires either prescription or over the counter medication during the school day:

- **Required Authorizations:** The school nurse must receive a signed Medication Authorization Form (see attached) signed by both a parent/guardian and the student's physician.
- **Medication Drop-Off/Pick-Up:** An adult (preferably a parent/guardian) must deliver or pick up a student's medication to/from the school nurse. Students are not allowed to transport medications.
- **Packaging Requirements:**
 - Prescriptions: Must be in the original pharmacy container labeled with the student's name, medication name, dosage, and usage instructions.
 - OTC Medications: Must be factory-sealed with the student's name written on the package.
 - All labeled medications are stored securely in the health office.
- **Supply Limits:** Please only provide the specific amount of medication needed during school hours.
- **Stocked Items:** The health office routinely stocks **only** Ibuprofen, Acetaminophen, and Diphenhydramine. Parents must supply all other OTC medications.
- **Medications for Self-Carry:** Students are strictly prohibited from carrying any medication at school. The only exceptions are **Inhalers** and **EpiPens**, which require independent carry permission from a physician. The self carry option can be found on the Asthma Action and/or FARE forms (both available on our website).

Please do not hesitate to contact the health office with any questions or concerns you may have. Karen Lacerra, RN BSN can be reached at (914) 725-6175 or by email at: klacerra@edgemont.org

Sincerely,

The Health Office Team

Medication Authorization Form

Edgemont Jr./Sr. High School Health Office
914-725-6175

Student's Name: _____ DOB: _____ Allergies: _____ Grade: _____

For both prescription and over the counter (OTC) medications given in school, the New York State Education Department requires prior written approval from both a healthcare provider and the parent/guardian. If your child requires any OTC medication, both your health care provider and you will need to complete this form and supply the OTC medication for your child. There are certain common OTC products listed below that will need physician and parent consent. Once completed, this form allows the school nurse to administer or apply the following OTC medications (from the health office stock supply) listed below to your child during school hours.

Medication	Indications	Instructions: (circle the dose allowed) Dosage/Route		Frequency	Health Care Provider Consent (Initial)	Parent/ Guardian Consent (Initial)
Tylenol (Acetaminophen) Tabs	Pain or fever >100.4	325mg 650mg	By Mouth	Every 4 hours as needed		
Advil (Ibuprofen) Tablets	Pain or fever >100.4	200mg 400mg	By Mouth	Every 6 hours as needed		
Benadryl (Diphenhydramine Hydrochloride) caps/tabs	Allergic reactions/hives	25mg 50mg	By Mouth	Every 4 hours as needed		
TUMS Chewables	Indigestion/Upset stomach	500mg 1000mg	By Mouth	Every 6 hours as needed		
Hand/body lotion: (Unscented) Eucerin or similar brand	Dry, itchy skin	Topical application to site				
Calamine lotion	Analgesic Anti-antipruritic	Topical application to site				
Alcohol liquid 70% & Alcohol prep pads	Skin protectant/ Antiseptic	Topical application to site				
Antibacterial: Benzalkonium	Antibacterial: First Aid	Topical application to site				
Aquaphor (Petrolatum)	Apply to dry and/or irritated/skin/lips	Topical application to site				
Purified water	Eyewash/Ophthalmic	Irrigation of eyes				
Contact Eye Solution: Bausch and Lomb or similar brand	Ophthalmic	For contact insertion				
Sting Relief swabs/ pads containing Ethyl alcohol/ Benzocaine 6%	Antiseptic and Analgesic	Topical application to site				
Burn Spray (Lidocaine HCL 2%)	Analgesic: For minor burns	Topical application to site				
Please indicate below any daily meds, prescription meds, or other OTC meds to be administered (provided by parent)						

To be completed by Health Care Provider:		
I authorize the medications I have initialed above to be administered to this student		
Name/Title of Licensed Prescriber: (please print)	License #:	Date:
*Signature:	Initials:	Phone:

To be completed by Parent/Guardian:		
Name: (please print)		Date:
*Signature:	Initials:	