

SMITHTOWN CENTRAL SCHOOL DISTRICT

PHYSICIAN'S ORDER FOR GIVING MEDICATION IN SCHOOL

PUPIL'S NAME _____ ADDRESS _____

PARENT/GUARDIAN NAME _____

TO PHYSICIANS AND PARENTS OF CHILDREN REQUIRING MEDICATION IN SCHOOL:

In compliance with the rules and regulations of the New York State Education Department, you are requested to complete this form so the following over the counter medication may be administered in school to your child.

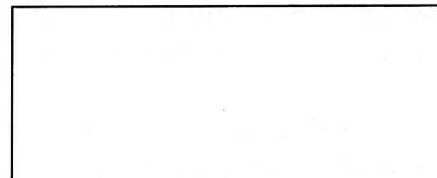
- ☐ Contact lens solution- for lens application and cleansing
- ☐ Calamine lotion- for bug bites, rashes, and comfort measures
- ☐ Witch Hazel- for skin irritation
- ☐ Cream or lotion- for dry skin, abrasions, burns
- ☐ Vaseline/A&D ointment/Aquaphor- for dry, chapped skin
- ☐ Mouthwash- for rinsing or cleansing mouth
- ☐ Salt water rinse/gargle

DOSAGE AND FREQUENCY _____

EFFECTIVE THE SCHOOL YEAR OF _____

Physician's Signature/Date

Physician's Telephone Number



Physician's Stamp

PARENT REQUEST TO SCHOOL TO GIVE MEDICATION

I, hereby request that my child, _____ be given the medication as prescribed by the physician. We, the parent/guardian, authorized the school to assist our child in taking medication and agree that we will not hold liable any member of the school staff or an individual of official capacity who is directed by us (the parent/guardians) and the school administrator to assist our child in taking said medication. The parent/guardian will note the expiration date of medication and will supply new medication when it is due to expire during the school year.

Parent/Guardian Signature