

**East Rochester Union Free School District**  
**OVER THE COUNTER MEDICATION FORM**

(Parent and Prescriber's Authorization for Administration of Medication in School)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Weight: \_\_\_\_\_

If you wish your child to receive **ANY** medication at school the **New York State regulation requires written permission from student's health care provider and parent**, this includes over-the-counter medications. Written permission must be renewed annually and **all over the counter medications MUST be in new, unopened packaging**. Administration of over-the-counter medications will be "per label" directions for age/weight unless otherwise indicated by provider.

Drug Name	Provider Order	Drug Name	Provider Order
Acetaminophen/Tylenol	Yes/No	Eye Drops	Yes/No
Antacid/Tums/Pepto Bismol	Yes/No	Ibuprofen/Advil/Motrin	Yes/No
Antibiotic Ointment	Yes/No	Midol	Yes/No
Antihistamine	Yes/No	Topical Hydrocortisone 1%	Yes/No
Cough Drops	Yes/No	Other:	Yes/No

**ALL MEDICATION MUST BE PROVIDED BY PARENT**

**Authorization Required:**

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Phone: \_\_\_\_\_ Provider Fax: \_\_\_\_\_

Elementary Health Office - Phone: 585-248-6317 Fax: 585-248-6326

Middle/High School Health Office - Phone: 585-248-6372 Fax: 585-248-6336