GOUVERNEUR CENTRAL SCHOOL DISTRICT
High School Health Department
113 East Barney Street
Gouverneur, New York 13642

Bev Martin, RN—Head Nurse

Dear Parent/Guardian:

Gouverneur Central School requires that the school have on file permission signed by the parent/guardian **and** the child's physician **before** we can administer **any** medication to your child. This includes both prescription and non-prescription (over-the-counter) medications.

After consultation with our school physician (Dr. Donald C. Schuessler, Jr.), we have decided to have available certain non-prescription medications in our Health Office for use by our nursing staff in the care of our students.

Please mark an "X" on the left of any medication you <u>DO NOT</u> wish your child to receive.

_____ ACETAMINOPHEN: _____mg every 4 hours as needed for mild headache, fever, musculoskeletal complaints, menstrual cramps, minor pain
_____ AMBESOL: for gum discomfort, toothache
_____ BACITRACIN/NEOSPORIN/NEOPOLYCIN: abrasions or superficial wounds after cleaning
_____ BLISTEX: chapped lips or cold sores
_____ CALAMINE: skin irritation /insect bites
_____ CHOLORASEPTIC: spray/gargle: minor sore throats
_____ CINDER SUDS: cleansing of abrasions
_____ CORTAID: minor skin rashes
_____ FIRST AID CREAM: minor cuts, abrasions
_____ FOILLE ointment & spray: floor burns
_____ GLYOXIDE: Minor mouth irritations
_____ IBUPROFEN: ____mg every 6 hours as needed for mild headaches, musculoskeletal complaints, menstrual cramps
_____ SALINE: wash foreign body from eye, contacts
_____ SOLARCAINE: minor sunburn
_____ SUNSCREEN
_____ COUGH DROPS prn sore throat/cough
_____ TUMS
_____ OTHER _____ as provided by parent

I give permission for the use of all the above medications in the treatment of my child **<u>EXCEPT the ones that are marked with an "X"</u>**, as deemed appropriate by the school nurse. This permission will remain in effect until I notify the School in writing.

Please note that both the parent/guardian and the child's physician for your child must sign this form to be able to receive these medications in the Health Office.

STUDENT NAME:_____ GRADE:_____

SCHOOL*: (circle one)* ELEMENTARY MIDDLE SCHOOL HIGH SCHOOL

Both Signatures are required

_____ _____
PARENT/GUARDIAN SIGNATURE Date

_____ _____
PHYSICIAN'S SIGNATURE Date

A <u>NEW</u> form must be signed and on file yearly.