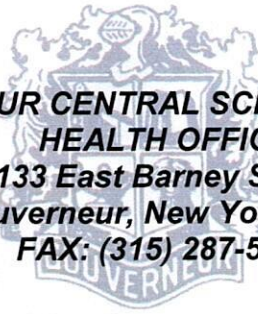


BEV MARTIN, RN
Head of Health Services
(315) 287-1902

KYLYNNE STAMPER, LPN
High School
(315) 287-1902

GOVERNEUR CENTRAL SCHOOL DISTRICT
HEALTH OFFICE
133 East Barney Street
Gouverneur, New York 13642
FAX: (315) 287-5517



NURSING STAFF

STACIE HALE, RN
BRITTANEY FAIRBANKS, LPN
Elementary School
(315) 287-4952

CHRISTINE SITTS, RN
NATALIE WOOD, LPN
Middle School
(315) 287-2260

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, 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 **DO NOT** 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 **EXCEPT the ones that are marked with an "X"**, 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 ST. JAMES PAROCHIAL

Both Signatures are required

PARENT/GUARDIAN SIGNATURE

Date

PHYSICIAN'S SIGNATURE

Date

A NEW form must be signed and on file yearly.