2035 MONROE AVENUE
ROCHESTER, NEW YORK 14618

TEL 585-242-5200
FAX 585-242-5164

DESTINY CHRISTIAN SCHOOL

FAX 585-473-2112

Dear Parents,

Whenever possible, the district asks that all medications, prescription and non-prescription, be given at home. For medicines given in school, the State Education Department requires that physicians write a prescription for prescribed and over-the-counter (OTC) medicines. Therefore, **for any medication, including all treatments listed below, PHYSICIAN SIGNATURE IS REQUIRED ON THIS FORM!**

PLEASE SIGN AND RETURN

School Nurse: Destiny Christian School Nurse

Child's Name: _____ Grade: _____
(Please Print)

☐ I give permission for the school nurse to administer as appropriate the following OTC products **only as checked** for my child for the current school year without a prior phone call:

- ☐ Petroleum Jelly or Aquaphor for chapped skin or lips
- ☐ Aloe Gel or Cream for a minor skin irritation
- ☐ Unscented hand and body moisturizing lotion
- ☐ Calamine lotion or Benadryl cream or spray for an itchy rash or insect bite
- ☐ Ophthalmic saline for contact lenses
- ☐ Bacitracin ointment for a minor skin cut, abrasion, or wound
- ☐ Acetaminophen (Tylenol) for headache pain (per package instructions)
- ☐ Ibuprofen (Advil) for menstrual, muscular-skeletal, or headache pain (per package instructions)
- ☐ Zinc oxide or titanium dioxide sunscreen to prevent sunburn
- ☐ Tums for indigestion (per package instructions)
- ☐ Chloraseptic spray for sore throat
- ☐ Saline (salt water) gargles for sore throat or rinses for mouth sore
- ☐ Ora-gel or Ambesol for a mouth sore, tooth pain, brace pain
- ☐ Cough drops for sore throat/cough

☐ I **do not** give permission for the above medicines unless I give prior verbal permission. I understand my child will not get the above products if I am unavailable.

_____ _____ _____
Parent Signature | Date | Daytime Phone

_____ _____ _____
Physician Signature **(REQUIRED)** | Date | Phone