PHYSICIAN & PARENT MEDICATION PERMISSION FORM 2025-26

*** *BOTH PARENT AND PHYSICIAN SIGNATURES ARE REQUIRED OR FORM IS INVALID****

The following requirements must be met in order for the Ashokan Center to legally administer **any** medications including over-the-counter (OTC) ; consistent with the **NYS Department of Education law 6902**

- A valid medication authorization form.
- **A parent/guardian and physician signatures.**
- Medications properly packaged.
- *These are explained in more detail below :*

A valid medication authorization form- An order from the prescriber is required for **both prescription and non-prescription medications.**

The provider order **must** include the following information:

- Date order is written.
- Student name and date of birth
- Medication name.
- Medication dosage.
- Medication route.
- Time and frequency the medication is to be administered
- The conditions under which the medication is to be administered if applicable.
- The provider's name, title, and signature.
- Provider's telephone number and address.
- **Provider's Office stamp.** A provider order must be in its original, unaltered form. Orders containing any edits render the order invalid.
- A provider order is typically valid for 12 months from the date of its issuance unless the provider changes the order, writes the order for a shorter period of time, or discontinues the order. Medications will be administered per the physician's written orders only.

Medications properly packaged:

- All prescribed medication **MUST be in a properly labeled pharmacy container only**. A parent may request an extra labeled medication container from their pharmacy in order to legally transport and safely administer medication during their child's stay at Ashokan.
- Please provide only enough medication for the trip, plus one extra dose.
- All OTC medications must be unopened and in their original container. Sealed blister packaging is acceptable.

Any medications arriving without valid orders and/or improperly packaged will be refused and returned to school staff attending the trip.

If you have any questions regarding medication administration or need to speak with a member of our Ashokan Center Medical Team, please email nurse@ashokancenter.org or call (845) 657-8333 Ext 21

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SCHOOL NAME:_____

STUDENT NAME:_____ DATE OF BIRTH:_____

PHYSICIAN NAME:_____ PHONE NUMBER:_____

The following over-the-counter medications are available at The Ashokan Center, and can be administered as needed per label instructions by age and weight. **Absolutely, NO** over--the--counter or prescription medications, supplements, vitamins, or topical ointments can be administered without a physician **and** parent's signature in accordance with **New York State Education Law, Title 139, Section 6902.**

PROVIDER: Please, indicate approval for administration by circling yes or no in the space indicated.

Medications	Route	Dosage	Time and Indications	May be Administered
Children's Tylenol (Acetaminophen)	By mouth (elixir or tablets)	Per label instructions By age and weight	Every 4-6 hours PRN pain or fever > _____°F	Yes No
Children's Motrin (Ibuprofen)	By mouth (elixir, suspension or tablets)	Per label instructions By age and weight	Every 6-8 hours PRN pain or fever > _____°F	Yes No
Benadryl (Diphenhydramine)	By mouth (elixir, tablets or capsules) Apply topically	Per label instructions By age and weight	Every 6 hours PRN allergies, or insect bites	Yes No
Claritin (Loratadine)	By mouth (elixir, suspension, or tablets)	Per label instructions By age and weight	Once Daily, PRN for seasonal allergies	Yes No
Tums (Calcium Carbonate)	By mouth (tablets)	Per label instructions ages 12 & up	Every 4-6 hours PRN acid indigestion	Yes No
Bacitracin Ointment	Apply topically	Bacitracin Zinc 500 U	Apply 1--3x Daily PRN minor cuts	Yes No
Antibacterial Ointment	Apply topically	Per label instructions By age and weight	Apply 1--3x Daily PRN minor cuts	Yes No
Hydrocortisone Cream 1%	Apply topically	Hydrocortisone 1%	Apply 3--4x Daily PRN skin irritation	Yes No
Calamine Lotion	Apply topically	Per label instructions	As needed PRN itching	Yes No

PROVIDER: Please document below current medication regimen including scheduled & PRN medications.

MEDICATION	ROUTE	DOSAGE	TIME	COMMENTS

Physician/ Provider Signature:_____ Date_____ License # _____

Parent/Guardian Signature: _____ Date_____ OFFICE STAMP