CENTER FOR SPECTRUM SERVICES
Brightening the lives of people with autism

70 Kukuk Lane
Kingston, NY 12401
tel: 845.336.2616
fax: 845.336.4153

4 Yankee Place
Ellenville, NY 12428
tel: 845.647.6464
fax: 845.647.3456

Jamey Wolff Program Director **Susan Buckler** Administrative Director
web: www.centerforspectrumservices.org

PHYSICIAN AUTHORIZATION TO ADMINISTER NON-PRESCRIPTION MEDICATION/TREATMENT

Name of Student:_____ Date of Birth:_____

Center for Spectrum Services' school nurse or designee needs written permission from parent and physician to administer non-prescription medication/treatment to your child. Below is a list of non-prescription medication/treatments that parents may request the school to administer as needed. Non-prescription medication/treatment must be sent to school in the original container, and must be transported by either the parent or given to the bus driver.

Please check where you give your consent. An age appropriate dosage will be given to your child when indicated at the discretion of the school nurse or designee.

I give my permission for the school nurse or designee to administer the above named non-prescription medication(s)/treatment(s) to my child. I accept all responsibility resulting from the effects of this non-prescription medication/treatment.

Consent Given Medication (please check)	**Indications**	**Other Indications**
_____Acetaminophen (i.e. Tylenol)	101 temp. or more	_____
_____Ibuprofen (i.e. Motrin, Advil)	pain	_____
_____Antibiotic ointment	cuts and bruises	_____
_____cough syrup* (i.e. Robitussin)	persistent coughs	_____
_____Diphenhydramine * (i.e., Benadryl, oral or topical)	allergic reaction	_____
_____sun screen*	exposure to sun	_____
_____insect repellent*	exposure to nature	_____
_____diaper rash cream* (i.e., Desitin)	irritation in diaper area	_____
_____hand and body lotion	dry skin	_____

*Provided by parent

Other:(please specify any other non-prescription medication/or homeopathic treatment your child may need)

_____

_____

_____ _____
Parent Signature Date

_____ _____
Physician Signature Date

Please stamp physician's name and address:

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