BEDFORD CENTRAL SCHOOL DISTRICT
**School Health Services**
THE FOX LANE CAMPUS, P.O. BOX 180
MOUNT KISCO, NEW YORK 10549
914-241-6000

Dr. Robert Glass
Superintendent of Schools

Dr. Louis Corsaro
Medical Director

# MEDICATION ORDER FOR BENADRYL ADMINISTRATION

*As outlined in the provisions of the New York State Education Law, school personnel are not allowed to dispense any medications (prescriptions or over-the-counter) to school children during school hours without a prescription from the prescribing physician. Parents/guardians must also sign this form giving permission for the medication to be administered in school. The completed form must be on file in the School Health Office before the medication may be administered.*

***All medication must be labeled with your child's name, dosage, and frequency of use.***

Student's Name _____ DOB: _____ Class: _____

**TO BE COMPLETED BY THE PHYSICIAN OR PRESCRIBING LICENSED HEATH CARE PROVIDER**:

Name of medication: _____

Dosage: _____ Route: _____ Frequency: _____

If medication is to be given "when needed", please circle indications:

1. Itchiness around mouth
2. Itchiness all over body
3. Rash (hives)
4. Other: _____

How soon can it be repeated? _____

Other actions to be taken: _____

**Signature of Physician or Licensed Prescriber**: _____ Date: _____

Print name: _____ Phone #: _____

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**TO BE COMPLETED BY THE PARENT/GUARDIAN**

*I hereby give my permission for the School Nurse to administer **Benadryl** to my child as specified by the above physician/provider. The medication is to be furnished by me in accordance with the Bedford Central School District's Medication Administration Protocols.*

**Parent/Guardian's Signature:** _____ Date: _____ Telephone: _____