This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.
***PARENTS! PLEASE SIGN AND DATE BOTH SIDES OF THIS FORM

**TUBERCULOSIS TESTING / SCREENING – EITHER A OR B MUST BE COMPLETED BY THE PHYSICIAN**

A. PPD (Mantoux):
   1. Date placed ________________ Date read ________________ Result in mm ________________
   2. If PPD is Positive: CXR: Date of exam: ____/____/____ Result: _____________________________
      Treatment:  ___________________________________________________________________________________
                      ___________________________________________________________________________________

B. Tuberculin screening not indicated ___________ (MD must initial)

**PRESCRIPTION MEDICATIONS**

Medications (list all):  

- Medication: ___________________________ Dosage/Time: ___________________________  
  
- Medication: ___________________________ Dosage/Time: ___________________________  
  
- Medication: ___________________________ Dosage/Time: ___________________________  

If AM dose is missed at home:  ________________________________________________________________________________________________

I assess this student to be self-directed  ☐ Yes  ☐ No  *Student may self carry and self administer medication  ☐ Yes  ☐ No

Note: Nurse will also assess self-direction for the school setting. *Students are not permitted to carry or self-administer USDEA controlled drugs. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

**PERMISSION TO RECEIVE PRESCRIPTION AND OVER THE COUNTER (OTC MEDICATION)**

Health Care Provider and Parent signatures required  

Parents must provide all medications.

- Tylenol (pain, fever)  
  Dose _____  Freq. _____  Route _____

- Ibuprofen (Advil, Motrin) (pain, fever)  
  Dose _____  Freq. _____  Route _____

- Benadryl (Allergic reaction/Allergy)  
  Dose _____  Freq. _____  Route _____

- Antacid (Maalox, Tums) (abdominal discomfort)  
  Dose _____  Freq. _____  Route _____

- Cough Drops/Throat Lozenges (sore throat)  
  Dose _____  Freq. _____  Route _____

- Antibiotic Ointment (skin lesions)  
  Dose _____  Freq. _____  Route _____

**SIGNATURES ARE REQUIRED IN ORDER FOR SCHOOL NURSE TO DISPENSE PRESCRIPTION AND OTC MEDICATION**

(Stamp below)

Provider’s Signature: ___________________________ Phone: ___________________________

Provider’s Name/Address: ___________________________ Fax: ___________________________

***Parent Signature: ___________________________ Date: ___________________________

Parental signature authorizes School Health personnel to communicate with your child’s physician regarding prescription and OTC medication.