

Prescription and Over-the-Counter Medication Consent Form
2025 SUNY Oneonta Migrant Leadership Academy (SOMLA)

If your child needs *any* kind of medication while at SOMLA, we need your consent for medication distribution *and* for the use of medical devices.

For prescription medications, we need additional information from the prescribing physician as well. See below.

Will your child require *prescription* medication(s) while at SOMLA? (This includes EpiPens and Inhalers.)

Yes	<input type="checkbox"/>	If "yes," <ol style="list-style-type: none"> 1. Please have your child's physician complete page 2. Submit the completed form with your other SOMLA application documents. 2. Staff at SOMLA must be made aware of the presence of EpiPens, inhalers, and/or other medications. 3. If students do not have prescription medications with them upon arrival at SOMLA, they will not be permitted to stay at SOMLA. <i>Important Note:</i> Prescription medications must be brought in their original containers bearing the pharmacy label and have specific instructions for use (Child's name, number of pills, prescribing practitioner, pharmacy name, pharmacy name and address, filler's initials, and serial number). 4. Your child will self-administer the medication. Should assistance be needed from SOMLA health services, please describe here:
No	<input type="checkbox"/>	If "no," your child <i>must not</i> be in possession of ANY medication while at SOMLA. You only need to complete and sign page one.

Will your child require *over-the counter* medications while at SOMLA?

Yes	<input type="checkbox"/>	If "yes," I give permission for my child to self-administer any of the over-the-counter medications listed below, in coordination with health services at SOMLA.
No	<input type="checkbox"/>	If "no," we will call you if your child is sick. You may verbally agree at that time that your child may take any over-the-counter medications shown below, in coordination with health services at SOMLA.

List of Over-the Counter Medications:

- Benadryl
- Claritin
- Midol
- Advil
- Pepto-Bismol
- If you believe another over-the-counter medication may be needed, please write it here:
- Tylenol
- Dimetapp
- Excedrin
- Cortaid

I understand and agree with the above criteria and processes regarding the administration of prescription and over-the-counter medication(s) at SOMLA.

Student Name: _____

Parent/Guardian Name: _____

Parent/Guardian Phone: _____

Parent/Guardian Signature: _____

Date: _____

Prescription Medications

This form should be completed by the prescribing physician.

Hello physician,

Your patient has been nominated to participate in the 2025 SUNY Oneonta Migrant Leadership Academy (SOMLA) from July 13, 2025, through July 18, 2025. As such, our health services team requests your assistance, using this form, if your patient must take prescription medication during SOMLA.

Patient Name: _____

Patient Date of Birth: _____

Medication #1

Name of prescription medication:	
General condition for which the medication is prescribed:	
Does the medication require refrigeration?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
Is there any other information that you think would be helpful for us to understand, in case of emergency, reactivity with other drugs, or otherwise?	

Medication #2

Name of prescription medication:	
General condition for which the medication is prescribed:	
Does the medication require refrigeration?	<input type="checkbox"/> Yes or <input type="checkbox"/> No
Is there any other information that you think would be helpful for us to understand, in case of emergency, reactivity with other drugs, or otherwise?	

Does your patient require an EpiPen during SOMLA? Yes or No

If "Yes," what is the reason the student requires an EpiPen? _____

Is the patient prescribed by a doctor to self-administer the EpiPen? Yes or No

If "Yes," was a prescription provided? Yes or No

Prescribing Physician's Information

Physician's Name: _____

Office Contact Phone Number: _____

Physician's Signature: _____