Permit to Provide Medication at School

Student Name: _____ Grade:_____

Important Information for Parents/Guardians:

1. Your written consent is required before your child may receive medications at school.
2. A physician's authorization will be required if ~

a. Your child requires more than 5 Consecutive daily doses of Tylenol (acetaminophen) or Motrin (Ibuprofen).

b. In the judgment of the school nurse, your child is ill and not improving

3. Your child's medication may be provided by the nurse, or by other school personnel determined competent to provide medication as required by Nebraska Law.
4. In the event your child is ill and school policies require exclusion from school, your child will be excluded, regardless of use of medication.

***** Please Be Sure To Mark ALL That Apply. *****

Name of Medication: Reason for Administering:

_____ Tylenol (acetaminophen) Headache, sore muscles, sprains, earache, sore throat, cramps, toothache

_____ Motrin (Ibuprofen) Headache, sore muscles, sprains, earache, sore throat, cramps, toothache

_____ Pseudoephedrine (Sudafed) Nasal Congestion

_____ Cough Drops Cough

_____ Antacid (Tums) Upset stomach

_____ Benadryl Sneezing, watery eyes. rash, allergic reaction

If your child is currently taking medications, please list below:

_____

Special instructions concerning your child:

_____

Parent/Guardian Si gnature _____ Date _____