Student Name: _____ School Year: 2023-2024

DOB: _____ Grade: _____ Advisory: _____

I give permission for my child to receive any medication checked below as deemed necessary by the School Nurse. I understand generic equivalents may be used and this permission will be in effect for only this school year. **My child has previously taken acetaminophen and ibuprofen without any adverse reaction**. By signing this form, I give permission for the Health Room staff to share this information with other school staff for the well-being of the child.

I would like the following(s) made available to my child (please check all that apply):

__ Acetaminophen/Tylenol for headaches, cramps, toothaches, etc.

__ Ibuprofen/Motrin or headaches, cramps, toothaches, etc.

__ Throat lozenges/Cough drops for sore throat/cough

__ Tums for nausea and stomachache

__ Calamine lotion/Caladryl cream for hives, rashes, poison ivy

__ Bacitracin ointment for wound care

__ Diphenhydramine (generic Benadryl) for severe allergic reactions – not for seasonal allergies

****Acetaminophen and Ibuprofen will not be given following a head injury or fever. They will only be given once during the school day and not during the first or last periods of the day.**

I understand that the above medications will be administered by the School Nurse in accordance with established protocols developed by the school physician and the School Nurse.

__ **I do not want any medication given to my child in school**

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____