Y.A.L.E. School

Consent for Administration of Acetaminophen and Ibuprofen

School Year 2019-2020

Name: _____
Date of Birth: _____

I give permission for my child, _____, to receive Acetaminophen and/or Ibuprofen as initialed below on this form if deemed necessary by the Registered Nurse/School Nurse. Dosage will be calculated by the dose recommendations already labeled on the medication according to the child's weight and age. I understand that generic equivalent medications may be used. Please note: if you would like to have any other medications administered to your child, the Consent for Administration for Prescribed Medication must be completed and signed by parent/guardian and a health care provider.

GRADE K-5

Acetaminophen (Tylenol) and Ibuprofen (Advil) per manufacturer's directions for child's weight and age, every 4 hours, as needed, for headaches, burns, earaches, muscle aches, brace pain and menstrual cramps.

Middle School – Grade 6-8 and High School – Grade 9-12

Acetaminophen (2) 325 mg tabs or Ibuprofen (2) 200 mg every 4 hours, as needed for headaches, burns, earaches, muscle aches, brace pain and menstrual cramps.

I understand that the medication I have checked will be administered by the Registered Nurse/School Nurse in accordance with established protocols developed by the School Physician.

_____ (**Initial**) I would like Acetaminophen (Tylenol) administered to my child as needed for headache, burns, earache, muscle aches, pain, and menstrual cramps.

_____ (**Initial**) I would like ibuprofen administered to my child as needed for headache, burns, earache, muscle aches, pain and menstrual cramps.

_____ (**Initial**) **I do not want any** medication given to my child in school.

PARENTS, PLEASE PROVIDE AND DELIVER CHEWABLE AND LIQUID MEDICATION

Parent/Guardian Signature_____
Date_____