AUTHORIZATION FOR THE ADMINISTRATION OF ASPIRIN-LIKE SUBSTITUTES
BY SCHOOL PERSONNEL

PARENT / GUARDIAN REQUESTS
WITHOUT A DOCTOR’S ORDER

The state law and regulations permit boards of education and schools to accept requests from parents/guardians to give aspirin-like substitutes (acetaminophen or ibuprofen) PRN (as needed) to a student. In such cases the order of a licensed physician, dentist, or APRN is not required.

PART I – To be signed by parent / guardian

Name of Child__________________________________ DOB________________________

Address __________________________________________ Drug Allergies______________

☐ ACETAMINOPHEN (Tylenol) 325 mg (1 – 2 tabs depending on weight & Liquid available depending on weight)
Condition for which medication is being administered during school hours: FEVER, MINOR PAIN, HEADACHE, TOOTHACHE
Method of administration: BY MOUTH Time of administration: PRN EVERY 6 HOURS
Medication to be administered from: SCHOOL YEAR (2023) until SCHOOL YEAR (2024)
Relevant side effects to be observed (if any) __________________________________________
If there are any side effects, notify the prescribing physician/dentist________________________

☐ Yes, I wish my child to receive Acetaminophen
☐ No, I do not wish my child to receive Acetaminophen

☐ Ibuprofen (Motrin) 200 mg (1 – 2 tabs Depending on weight & Liquid available depending on weight)
Condition for which medication is being administered during school hours: FEVER, MINOR PAIN, HEADACHE, TOOTHACHE
Method of administration: BY MOUTH Time of administration: PRN EVERY 6 HOURS
Medication to be administered from: SCHOOL YEAR (2023) until SCHOOL YEAR (2024)
Relevant side effects to be observed (if any) __________________________________________
If there are any side effects, notify the prescribing physician/dentist________________________

☐ Yes, I wish my child to receive Ibuprofen
☐ No, I do not wish my child to receive Ibuprofen

I hereby request that the medication listed above be administered to my child by the appropriate school personnel and in accordance with state regulations.

Parent/Guardian Name: ___________________________ Relationship to Child: ________________

Signature: ___________________________ Date: ___________________________

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PART II – To be signed by school personnel

I hereby request that the medication listed above be administered to my child by the appropriate school personnel and in accordance with state regulations.

School Personnel: ___________________________ Date: ___________________________

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Revised: 5/2023 Nurse Cheryl
The state law requires a written order of a physician licensed to practice medicine in this state and the written authorization of a parent or guardian of such child for a school nurse, the principal or any teacher, or coach to administer medicinal preparations to any student.

PART II – To be signed by a Physician / Dentist / APRN

Name of Child: ____________________________________________ DOB: ______________________________

Medication to be administered from: SCHOOL YEAR (2023) until SCHOOL YEAR (2024)

☐ Throat lozenge (1)
   Condition for which medication is being administered during school hours: COUGH, THROAT IRRITATION
   Method of administration: BY MOUTH Time of administration: PRN Q2 HOURS
   Relevant side effects to be observed (if any) ________________________________

☐ Yes, permission to give my child throat lozenges
☐ No, I do not wish my child to receive lozenges

☐ Benadryl (25 – 50mg)
   Condition for which medication is being administered during school hours: ALLERGY, ALLERGIC REACTION
   Method of administration: BY MOUTH Time of administration: PRN Q 4 HOURS
   Relevant side effects to be observed (if any) ________________________________

☐ Yes, permission to give my child Benadryl
☐ No, I do not wish my child to receive Benadryl

☐ Antacids (Tums)
   Condition for which medication is being administered during school hours: HEARTBURN, EPIGASTRIC DISTRESS
   Method of administration: BY MOUTH Time of administration: PRN Q 4 HOURS
   Relevant side effects to be observed (if any) ________________________________

☐ Yes, permission to give my child to antacids
☐ No, I do not wish my child to receive antacids

☐ OTC (Goldbond Powder, Tea Tree Oil, Caladryl, Sunscreen, other): __________________________ Medication Name/Dose
   Condition for which medication is being administered during school hours: __________________________
   Method of administration: TOPICAL Time of administration: PRN
   Relevant side effects to be observed (if any) ________________________________

☐ Yes, I wish my child to receive
☐ No, I do not wish my child to receive

M.D./Dentist/APRN SIGNATURE __________________________________________ Date: ________________
M.D. Address: __________________________________________ Phone: _______________________

Parent / Guardian Signature: __________________________ Drug Allergies: ________________________________

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