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.

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PART I – To be signed by parent / guardian

Name of Child_____DOB_____

Address _____Drug Allergies_____

☐ **ACETAMINOPHEN (Tylenol) 325 mg (l – 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 (l – 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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PARENT / PHYSICIAN SIGNATURE

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.

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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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Revised: 5/2022 Nurse Cheryl