20 -20 School Year

PARENT/ GUARDIAN AUTHORIZATION
TO ADMINISTER PRN MEDICATION IN SCHOOL

(To be kept confidential upon completion)

Name of Student: _____ **DOB:** _____ **Grade:** _____

Diagnosis/Illness: _____

_____ **Medication**: Tylenol/ Acetaminophen

Dosage/Route: 325mg-650mg (based on age and weight) By Mouth

Frequency/Time: Every 4-6 Hours as needed for headaches/ pain

Special Directions: _____

Possible side effects: _____

_____ **Medication:** Advil/Motrin/Ibuprofen

Dosage/Route: 200 mg-400 mg (based on age and weight) By Mouth

Frequency/Time: Every 6-8 Hours as needed for headaches/ pain

Special Directions: _____

Possible Side Effects: _____

_____ **Medication**: TUMS/ Antacid

Dosage/Route: 1-2 Tablets (based on age and weight) By Mouth

Frequency/Time: As needed for stomach discomfort according to manufacturer's directions.

Special Directions: _____

Possible Side Effects: _____

I/We authorize the School Nurse or, in his/her absence, the principal or his designee, to administer the above medication as indicated by my initials. I/We understand and agree that the School, the School Nurse and the Principal shall not be liable for any injury to the student resulting from the administration of the medication as authorized by my signature below.

_____ _____

(Signature of Parent/Guardian) (Print) Date