



ALL SAINTS ACADEMY

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Written Parent/Guardian Authorization For Administration of Tylenol (Acetaminophen)/ Motrin (Ibuprofen) Or Non-Prescription Medications

Student Name: _____

Date of Birth: _____ Grade/Teacher: _____

Parent/Guardian Name(s): _____

Phone Numbers: Home: _____

Work: _____

Cell: _____

My son/daughter is currently taking the following medication(s): (Please list both prescription and non-prescription medication)

My son/daughter has the following allergies: _____

Elementary Students: Tylenol (acetaminophen) dose is calculated by weight. My child's current weight is _____

Middle School Students: receive the standard recommended dose:

- I give permission to the School Nurse or other trained staff to administer OTC medication to my child, _____, according to the established policy.
- I give permission to the School Nurse to share with appropriate school personnel, information relative to medication administration, indications, side effects, etc., as necessary for my son's/daughter's health & safety.
- I understand that the School Nurse/Staff must speak directly with a parent/guardian prior to each medication administration.

Parent/Guardian Signature _____ Date: _____

Parent/Guardian (Printed Name) _____