

**Ashford School
440 Westford Road
Ashford, CT 06278**

**ACETAMINOPHEN (TYLENOL)/IBUPROFEN PERMISSION SLIP
AND MEDICATION RECORD**

Parent Authorization

Student's Name _____
Grade _____ Teacher _____ Allergies _____

Under the standing orders of the medical advisor, Acetaminophen (Tylenol) or Ibuprofen may be given to students with parent's authorization. Acetaminophen may be administered by mouth every four to six hours; Ibuprofen may be administered every six hours for symptoms of the common cold, toothache, dental brace discomfort, menstrual cramps, earache, fever, simple headache, and minor joint and muscle pain. Please complete the following if you wish your child to have this medication in school.

I give ASHFORD SCHOOL permission to administer (CHECK ONE/BOTH)
_____ Acetaminophen _____ Ibuprofen to my child as needed.

No allergy to this medication is presently known. I will notify the school nurse if at any time in the future my child should not receive this medication. This permission will be in effect until the end of the school year.

I understand that for any potentially serious illness, or accident, or for re-occurring problems, I will be contacted with further recommendations.

Date _____ Parent/Guardian Signature _____
Phone(H) _____ (W) _____ (C) _____

Date m/d/y	Time Given		Legal Signature of Nurse/Principal/Teacher		Comments
	am	pm	Medication and Dose Given	Administering Medication	

File in Student's Cumulative Health Record when medication has been completed or discontinued.

