Marshall County Central

Authorization for Administration of Tylenol/Advil

School Year: _____

Student Name:	Grade:
Parent(s)/Guardian:	
Address:	
Phone # (please specify)	

Medication Name: acetaminophen (Tylenol) OR ibuprofen (Advil/Motrin)

Dosage Needed (cannot exceed manufacturer's dose for age/weight):

Reason requiring medication: discomfort related to headache, sore throat, toothache, earache, menstrual pain or other (please specify)

- Medication **CANNOT** be given more than **2 consecutive days**
- You must supply a small bottle of the medication for school use.
- The medication must be in the original bottle with original manufacturer's label.
- Please label the bottle with your child's first and last name.
- The bottle will be kept in the school office and administered by staff.
- This form must be completed and signed before any medication will be administered.

I request and give my permission for staff to administer the above medication to my child. I understand it is my responsibility to provide the school with the medication. I further understand that the district is rendering a service and does not assume responsibility for this matter.

Signature of Parent/Guardian: _____ Date: _____

PLEASE RETURN COMPLETED FORM TO THE SCHOOL NURSE

Reviewed/Date _____