Student's Name________________________

REQUEST TO PROVIDE MEDICATION DURING SCHOOL HOURS:
ACETAMINOPHEN/IBUPROFEN/TUMS
Magnolia Public School- 2024-2025

IMPORTANT INFORMATION FOR PARENTS/GUARDIANS:
Your written consent is required before your child may receive these medications at school. Please complete the entire form. By signing below, you acknowledge the following:
1-You have reviewed the information and agree that your child may safely take the medications according to the recommended dose by weight.
2- The school nurse has the responsibility of approving your child's use of these medications. In the case of a child with special health care needs, the school nurse may request authorization from your physician.
3- A licensed prescriber's authorization will be required if: Your child requires more than 2 doses of acetaminophen and/or ibuprofen within a week.

PARENTAL CONSENT FOR ACETAMINOPHEN AND/OR IBUPROFEN:
I give permission for to receive the following medication: (*please circle*)

Acetaminophen (Tylenol)

Ibuprofen (Advil)

Tums

*Please notify me before my child takes medications: Yes No
Contact Name and Phone Number:________________________________

My child is taking other medication at this time: Yes No
Please list medications: ____

Signature of Parent/Guardian:____
Date:________________________