HS0059
Rev. 3/23

REQUEST TO PROVIDE MEDICATION DURING SCHOOL HOURS: ACETAMINOPHEN AND IBUPROFEN

Health Services Department
Lincoln Public Schools • Lincoln, Nebraska

IMPORTANT INFORMATION FOR PARENTS/GUARDIANS:

Your written consent is required before your student may receive these medications at school. Please complete the entire form. By signing below, you acknowledge the following:

- You have reviewed the information and agree that your student may safely take the medications *according to the recommended dose by weight.*
- The school nurse has the responsibility of approving your student's use of these medications. In the case of a student with special health care needs, the school nurse may request authorization from your physician.
- A licensed prescriber's authorization will be required if:
  - Your student requires more than 2 doses in a single week.
  - Your student requires more than 5 doses of acetaminophen and/or ibuprofen in a 30 day period;
  - **In the judgement of the school nurse, your student is ill and not improving.**
- Your student's medication may be provided by a nurse, an unlicensed health technician, or other school personnel, determined competent to provide medication as required by Nebraska law.
- These medications are provided for use during school hours and will be limited to one dose per day. Purpose of medication is to benefit learning and attendance.

PARENTAL CONSENT FOR ACETAMINOPHEN AND/OR IBUPROFEN:

I give permission for: _____
Student Name

To receive the following medication: ***Acetaminophen (Tylenol)*** ❑ **Yes** ❑ **No** | ***Ibuprofen (Advil)*** ❑ **Yes** ❑ **No**

Has your student experienced negative side effects from acetaminophen: ❑ Yes ❑ No

If yes, explain: _____

Has your student experienced negative side effects from ibuprofen: ❑ Yes ❑ No

If yes, explain: _____

Please notify me **BEFORE** my student takes medications: ❑ Yes ❑ No

Please notify me the day my student takes medication: ❑ Yes ❑ No

Contact Name: _____ Phone: _____

Please contact the School Nurse if your student has Special instructions concerning administration of Acetaminophen or Ibuprofen.

Signature of Parent/Guardian: _____ Date: _____