REQUEST TO PROVIDE MEDICATION DURING SCHOOL HOURS:  
ACETAMINOPHEN AND IBUPROFEN
Health Services Department
Lincoln Public Schools

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:

- You have reviewed the information and agree that your child may safely take the medications according to the recommended dose by weight.
- 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.
- A licensed prescriber’s authorization will be required if:
  - Your child requires more than 5 doses of acetaminophen and/or ibuprofen in a 30 day period;
  - Your child requires more than 5 consecutive doses of acetaminophen and/or ibuprofen
  - In the judgement of the school nurse, your child is ill and not improving.
- Your child’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.

PARENTAL CONSENT FOR ACETAMINOPHEN AND/OR IBUPROFEN:

I give permission for ___________________________ to receive the following medication:

**Acetaminophen (Tylenol) ______________________________ Ibuprofen (Advil) ______________________________

Reason(s):  Headache ______________________________ Menstrual Cramps ______________________________
            Dental Pain ______________________________ Muscle or Joint Pain ______________________________
            General Discomfort ______________________________ Other ______________________________

My child has taken acetaminophen before:  ❑ Yes  ❑ No without a problem:  ❑ Yes  ❑ No
My child has taken ibuprofen before:  ❑ Yes  ❑ No without a problem:  ❑ Yes  ❑ No

Please notify me before my child takes medications:  ❑ Yes  ❑ No
Please notify me the day my child takes medication:  ❑ Yes  ❑ No

Contact Name and Phone # ______________________________

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

My child is under the care of a physician for the following: ______________________________

Special instruction concerning my child: ______________________________

Signature of Parent/Guardian ______________________________ Date ______________________________

Please List