HS0059
Rev. 11/16

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.
- ❑ These medications are provided for use during school hours and may be limited. Purpose of medication is to benefit learning and attendance. These medications will not be administered the last hour of school day except at the discretion of school nurse.

PARENTAL CONSENT FOR ACETAMINOPHEN AND/OR IBUPROFEN:

I give permission for _____
Child's name

To receive the following medication:

Acetaminophen (Tylenol) **❑ Yes ❑ No** ***Ibuprofen (Advil)*** **❑ Yes ❑ No**

Has your child experienced negative side effects from acetaminophen ❑ Yes ❑ No

If yes, explain _____

Has your child experienced negative side effects from ibuprofen ❑ Yes ❑ No

If yes, explain _____

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*

MEDICATION LOG
Health Services Department

Student Name: _____ ID #: _____ Physician: _____

Date Started: _____ Medication: _____ Dosage: _____ Time: _____ Frequency: _____

Teacher: _____ Room-Team-Grade: _____ Permit: ❑ M.D. ❑ Parent

Special Instructions: _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
August																															
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January																															
February																															
March																															
April																															
May																															
June																															

Time and initials must be recorded for each administration.

Int.: _____ Name: _____ Int.: _____ Name: _____

Int.: _____ Name: _____ Int.: _____ Name: _____

Int.: _____ Name: _____ Int.: _____ Name: _____

KEY	
H: No School Day	**N:** No ℞
/: Weekend	**R:** Refused
A: Absent	**SN:** See Note
***:** Office Staff	**F:** Field Trip