HS0059
Rev. 10/18

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 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 will be limited to one dose per day. 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: _____
Student 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: _____ 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																															
September																															
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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