Y.A.L.E. School
Consent for Administration of Acetaminophen
School Year 2016-2017

Name:_____
Date of Birth:_____

I give permission for my child, _____
to receive acetaminophen as checked below on this form if deemed necessary by the Registered Nurse/School Nurse. Dosage will be calculated by the dose recommendations already labeled on the medication according to the child's weight and age. I understand that generic equivalent medications may be used. Please note: if you would like to have any other medication administered to your child, the Consent for Administration for Prescribed Medication must be completed and signed by parent/guardian and a health care provider.

GRADE K – 5

Acetaminophen (tylenol) per manufacturer's directions for child's weight and age, every 4 hours, as needed, for headaches, burns, earaches, muscle aches, brace pain and menstrual cramps.

MIDDLE SCHOOL – GRADE 6-8 and HIGH SCHOOL – GRADE 9-12

Acetaminophen (2) 325mg tabs every 4 hours, as needed for headaches, burns, earaches, muscle aches, brace pain and menstrual cramps.

I understand that the medication I have checked will be administered by the Registered Nurse/School Nurse in accordance with established protocols developed by the School Physician.

_____ I would like acetaminophen administered to my child as needed for headache, burns, earache, muscle aches, pain, menstrual cramps.

_____ I do not want any medication given to my child in school.

** PARENTS, PLEASE PROVIDE AND DELIVER CHEWABLE AND LIQUID MEDICATION **

_____ _____
Parent/Guardian Signature Date

SIGNATURE REQUIRED

Rev 8/12