

Y.A.L.E. School  
Consent for Administration of Acetaminophen and Ibuprofen  
School Year 2018-2019

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

I give permission for my child, \_\_\_\_\_  
To receive acetaminophen and ibuprofen as initialed 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 medications 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) and Ibuprofen (Advil) 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) 325 mg tabs or ibuprofen (2) 200 mg 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.

\_\_\_\_\_(Initial) I would like acetaminophen administered to my child as needed for headache, burns, earache, muscle aches, pain, and menstrual cramps.

\_\_\_\_\_(Initial) I would like ibuprofen administered to my child as needed for headache, burns, earache, muscle aches, pain and menstrual cramps.

\_\_\_\_\_(Initial) 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**