SEDALIA SCHOOL DISTRICT #200

PARENT PERMISSION FOR MEDICATION ADMINISTRATION
(FOR GRADES 9-12 ONLY)

Name of student:_____ Grade: _____

❑ Acetaminophen 325mg, 1-2 tablets

❑ Ibuprofen, 200mg 1-2 tablets

I authorize and request the school nurse or other trained school personnel to administer the above medication to my student for the following indications: mild to moderate pain, headache, and menstrual pain.

I understand that the school nurse or other trained school personnel will contact me for verbal permission each time, before a dose is administered.

_____

Parent/Guardian Signature Date

SCHOOL NURSE ACKNOWLEDGEMENT

_____ _____ _____

SCHOOL NURSE NAME SCHOOL NURSE SIGNATURE DATE