

Ewing Public Schools

Request to Provide Medication during School Hours: Acetaminophen

Important information for Parents / Guardians:

Your written consent is required before your child may receive Acetaminophen in school. Please complete the entire form. By signing below you acknowledge the following:

- 1- You have reviewed the information and agree that your child may safely take acetaminophen according to the recommended dose by weight and / or age.
- 2- The School Nurse has the responsibility of approving your child's use of this medication. In case of a child with special health care needs, the School Nurse may request authorization from your physician. **The School Nurse will communicate with the parent / guardian for all students under the age of 14 years.**
- 3- A licensed prescriber's authorization will be required if:
 - A – Your child requires more than 5 doses of acetaminophen in a 30 day time frame.
 - B- Your child requires more than 5 consecutive doses of acetaminophen.
 - C- In the judgment of the School Nurse, your child is ill and not improving.

Parental Consent for Acetaminophen:

I give permission for _____ to receive the medication Acetaminophen.

Reason(s): Headache _____ Menstrual Cramps _____
Dental Pain _____ Fever _____
General Discomfort _____ Other _____

My child has taken acetaminophen before ____yes ____no: without a problem: ____yes ____no.

Please list all medications taken at home: _____

My child is under the care of a physician for the following:

Special instructions concerning your child: _____

_____ Date _____

Parent / Guardian signature