Arlington School – 115 Mill Street, MS 111, Belmont, MA 02478 – (617) 855-2124

Over –the-Counter Medication Administration and Consent Form

Student Name _____ **DOB** _____

Height _____ Weight _____ Gender _____ Grade _____

Primary Address _____

_____ Zip _____

Parent #1	_____	Parent #2	_____
Home	_____	Home	_____
Cell	_____	Cell	_____

Person to be notified in an emergency, in case parent/guardian cannot be reached:

Emergency Contact _____
Phone Number _____
Relationship _____

Please list **all** over-the-counter **medication/vitamins** your child receives including those given during the school day (Tylenol, Ibuprofen, Advil, Multi-Vitamin, Tums, etc.).

1. _____	2. _____	3. _____
Dose: _____	*Dose:* _____	*Dose:* _____
4. _____	5. _____	6. _____
Dose: _____	*Dose:* _____	*Dose:* _____

Protocol to administer Tylenol or Ibuprofen to students during school hours:

Tylenol (650 mg)	650mg may be administered to a student every four hours for headache or menstrual cramps with written parent/guardian authorization and documentation on Medication Log for each student.
Indications	for treatment of menstrual cramps or headache not associated with other conditions
Contraindications	sensitivity to acetaminophen or aspirin
Potential Adverse Effects	Incidents of adverse effects is very rare with Tylenol. They include agranulocytosis (fever, sore throat, white sore spots on the lips or in the mouth), anemia allergic dermatitis, and renal failure.

Ibuprofen (400mg to 600mg)	400mg to 600mg may be administered to a student every six hours for headache or menstrual cramps with written parent/guardian authorization and documentation on Medical Log for each student.
Indications	for treatment of menstrual cramps or headache not associated with other conditions
Potential Adverse Effects	gastrointestinal irritation (can be helped by taking with food), increased toxic effects if combined with Lithium.

CONSENT

I give permission to the Arlington School Nurse, or an authorized school staff member, to give the following medicine(s) to my child:

☐ Tylenol (650mg) every 4 hrs _____ _____

☐ Ibuprofen (400mg/600mg) every 6 hrs _____ _____

I give permission to my child to self administer over-the-counter medication if the school nurse determines it is safe and appropriate: ☐ YES ☐ NO

I give permission to the school nurse to share with appropriate school personnel information relating to the administration of the above consented over-the-counter medications in relation to my child's health and safety. ☐ YES ☐ NO

_____ _____

Signature of Parent/Guardian **Date**

_____ _____

Student's Signature if 18 years of age or older **Date**