PEORIA
UNIFIED SCHOOL DISTRICT NO. 11

HIGH SCHOOL
ACETAMINOPHEN/IBUPROFEN FORM

Dear Parent/Guardian:

Occasionally your child may unexpectedly need acetaminophen/ibuprofen during a school day. For these occasions, the school nurse may maintain a **LIMITED** supply of these medications.

Please complete the form below and return it to the school nurse if you want your child to receive acetaminophen/ibuprofen during the school day.

IF YOUR CHILD NEEDS ACETAMINOPHEN FOR AN EXTENDED TIME OR FOR A CHRONIC CONDITION, YOU *MUST* SUPPLY THE MEDICATION.

Name of Student ______________________________ Date of Birth ____________

Grade ______________ Guidance Counselor ____________________________

My child may receive the medication(s) checked below:

YES	MEDICATION	DOSAGE	FREQUENCY
	Acetaminophen (Tylenol)	1 adult regular = 325 mg.	every 4 hours if necessary
	Acetaminophen (Tylenol)	2 adult regular = 650 mg.	every 4 hours if necessary
	Ibuprofen 200mg (Advil)	1 regular strength = 200 mg	every 6 hours if necessary
	Ibuprofen 200mg (Advil)	2 regular strength = 400 mg	every 6 hours if necessary

PLEASE DO NOT ADD ANY MEDICATION TO THIS FORM

I authorize the school nurse or the principal’s designee to be my agent to give the medication(s) checked above to my child.

____
Signature of Parent/Guardian

____
Date

FOR OFFICE USE ONLY

Doctor's Name: ____________________
Student's Name: ____________________

Prescription Number: ____________________
Diagnosis: ____________________

Pharmacy Name: ____________________
Teacher's Name: ____________________

Amount of medication brought to school:

Date: _______ Rec'd. _______ Tabs, Caps, Liq, Inhaler
Date: _______ Rec'd. _______ Tabs, Caps, Liq, Inhaler
Date: _______ Rec'd. _______ Tabs, Caps, Liq, Inhaler
Date: _______ Rec'd. _______ Tabs, Caps, Liq, Inhaler
Date: _______ Rec'd. _______ Tabs, Caps, Liq, Inhaler
Date: _______ Rec'd. _______ Tabs, Caps, Liq, Inhaler
Date: _______ Rec'd. _______ Tabs, Caps, Liq, Inhaler
Date: _______ Rec'd. _______ Tabs, Caps, Liq, Inhaler
Date: _______ Rec'd. _______ Tabs, Caps, Liq, Inhaler
Date: _______ Rec'd. _______ Tabs, Caps, Liq, Inhaler

Medication & Dosage: ____________________

Expiration Date: ____________________

Time to be given: ____________________

Daily __________ PRN __________

Special Instructions: ____________________
____
____

	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	Comments:
August											11	12	13	14	15	18	19	20	21	22	25	26	27	28	29	
September	1	2	3	4	5	8	9	10	11	12	15	16	17	18	19	22	23	24	25	26	29	30				
	▨																									
October			1	2	3	6	7	8	9	10	13	14	15	16	17	20	21	22	23	24	27	28	29	30	31	
											▨								TC	TC						
November	3	4	5	6	7	10	11	12	13	14	17	18	19	20	21	24	25	26	27	28						
							▨												▨	▨						
December	1	2	3	4	5	8	9	10	11	12	15	16	17	18	19	22	23	24	25	26	29	30	31			
															▨	▨	▨	▨	▨	▨	▨	▨	▨			
January				1	2	5	6	7	8	9	12	13	14	15	16	19	20	21	22	23	26	27	28	29	30	
				▨	▨											▨										
February	2	3	4	5	6	9	10	11	12	13	16	17	18	19	20	23	24	25	26	27						
									TC	TC	▨															
March	2	3	4	5	6	9	10	11	12	13	16	17	18	19	20	23	24	25	26	27	30	31				
											▨	▨	▨	▨	▨											
April			1	2	3	6	7	8	9	10	13	14	15	16	17	20	21	22	23	24	27	28	29	30		
																				▨						
May					1	4	5	6	7	8	11	12	13	14	15	18	19	20	21	22						
																			SLD	TLD						

LEGEND:

A-Absent	O-Medication not given
ED-Early Dismissal	N-No medication at school
F-Field Trip	___ (initial)-Medication taken as directed
▨-No School	DC-Discontinued
SLD-Students Last Day	
TLD-Teachers Last Day	

PRN's:
SVN's: } Document time of administration

End of year disposition of medication:
Date _________ #of Tabs, Caps, cc/oz. Bottle, Inhaler,
sent home with: ____________________

Person(s) administering medication:
____

2008-2009 SCHOOL YEAR

Revised 2/08