I authorize the Health Office to administer Tylenol, Acetaminophen or Ibuprofen to my child as needed for headache, etc.

Parent/Guardian (print/signature): ________________________ ______________________________

Life Threatening Allergies (food, bee stings, medications, other) ____
Epinephrine required for treatment of allergies: Yes or No
Asthma/EIA/RAD - Requires medication/inhaler: Yes or No

If yes to the above, please consult the school nurse. Epinephrine and inhaler orders must be completed before the start of each school year.

Name and dosage of medication your child must take, during school hours: ______________________________
And at home: ____________________________________

All medications for students must be delivered to and from school by the parent or designated adult. *A doctor's note must accompany a parent's note for administration*. Medications are never to be in a student's possession and must be in the original container. Asthma medication and EpiPens may be in a student's possession *when* special consent forms *have been completed*, for each school year.

X Share Medical Alerts with Teachers and Staff
In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, or the alternate contacts listed on the other side of this form, I hereby authorize the school to call the physician indicated above and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements are necessary.

Parent/Guardian (print/signature): _______________________ ____________________________
Date: ______________

Family Physician: ____________________________________ Phone Number: _____________________

Family Dentist: ______________________________________ Phone Number: _____________________

Hospital: ____ Phone Number: _____________________