ANDOVER PUBLIC SCHOOLS
DEPARTMENT OF HEALTH SERVICES

CONSENT FOR ACETAMINOPHEN/IBUPROFEN ADMINISTRATION

Name of Student_________________________DOB____________Grade__________School________

Address____Tel. #____________________

MEDICATION ORDER:

Medication: Acetaminophen Dosage: 325 – 650 mg. Route: By Mouth Frequency: q 4 hrs. PRN

Diagnosis: Pain, headache, fever (Temp > 101 degrees F)

Medication: Ibuprofen Dosage: 200 – 400 mg. Route: By Mouth Frequency: q 6 hrs. PRN

Diagnosis: Pain, headache, Temp >101 degrees F

Duration: For the current school year Side Effects: Risk of bleeding with Ibuprofen Self- administration: No

Licensed Prescriber: Dr. Kenneth Chan, Andover school physician ph: 978-475-4522

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PARENT / GUARDIAN PERMISSION:

________I give permission for the school nurse, or school personnel designated by the school nurse, to administer acetaminophen / ibuprofen (**circle each one**) to my child from ____________________to______________________.

I give permission for the school nurse to share information relative to this prescribed medication with appropriate school personnel if it is necessary for my child's health and safety.

This student has the following allergies/medical conditions____

This student is currently taking these other medications (including those not given at school)______________________

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Parent / Guardian Signature_______________________________________Date______________________

Student Signature (18 yrs. old +)___________________________________Date______________________

Home Tel. #______________________Work #_____________________Cell #______________________

Other person to call in emergency if parent is not available_________________________Tel. #_________________

Revised 06/2011