

MORRIS COUNTY SCHOOL OF TECHNOLOGY

Parent Authorization for Medication to be Taken During School Hours

Student's Name _____ Date of Birth _____

Academy _____ Grade _____

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons.

| | |
|---------------------------------------|---------|
| _____ | _____ |
| Parent/Guardian Signature | Date |
| _____ | _____ |
| Parent/Guardian's Name (please print) | Phone # |

Physician Authorization for Medications to be Taken During School Hours

DIAGNOSIS (please check):

HEADACHE FEVER MENSES OTHER: _____

MEDICATION (please check):

IBUPROFEN (ADVIL) 400MG PO PRN EVERY 6 HOURS AS NEEDED

ACETAMINOPHEN 650mg PO PRN EVERY 4 HOURS AS NEEDED

WHEN NEEDED (PRN) INDICATIONS:

- Mild to moderate pain due to headache.
- Fever greater than 100 degrees Fahrenheit.
- Pain due to dysmenorrhea.

POSSIBLE SIDE EFFECTS: Increase Headache, dizziness, drowsiness, fatigue, tremors, confusion, insomnia, anxiety, depression, nausea, vomiting, abdominal pain.

LENGTH OF TIME MEDICATION IS TO BE CONTINUED: School year _____

| | |
|-----------------------|---|
| _____ | _____ |
| Physician's Signature | Date |
| | <i>Must be dated after 7/1 for current school year.</i> |

Physician's Stamp (include phone and fax numbers):