WOLCOTT PUBLIC SCHOOLS HEALTH SERVICES
Wolcott, Connecticut 06716

THIS FORM IS OPTIONAL. It is to be completed by the student's **physician, only** if you would like Tylenol (Acetaminophen) and/or Motrin (Ibuprofen) to be available to your child if he/she becomes ill during school (**2019 – 2020** school year).

_____ _____ _____ may have during school hours:
Name of student **Grade** **School**

Tylenol _____
dose (325 mg. Tablets or liquid available)

(P.O.) every _____ hours prn for:
route

(symptoms/signs): _____.

(duration of symptoms) _____.

If exceeds _____ times per month, parent/physician to be notified.

Contraindications to the administration of this medication include: _____

_____.

Ibuprofen _____
dose (200 mg. Tablets or liquid available)

(P.O.) every _____ hours prn for:
route

(symptoms/signs): _____.

(duration of symptoms) _____.

If exceeds _____ times per month, parent/physician to be notified.

Contraindications to the administration of this medication include: _____

_____.

_____
Physician name (Please Print)

_____
Signature of prescribing physician

_____
Phone Number

_____
Provider Stamp

I give permission for my child to receive the above medication(s) from the Wolcott Public School Nurse.

Parental/guardian signing of this form allows the nurse to confer with the prescribing physician when necessary regarding the above order.

_____
Date

_____
Signature of Parent/Guardian