

Wausau School District

Acetaminophen/Ibuprofen Consent Form

The Wausau School District will supply generic ibuprofen and generic acetaminophen for students in the middle schools and high schools. (WSD elementary schools will not provide stock medications.)

Written permission is required for administration of ibuprofen or acetaminophen.

Wausau School District personnel will only administer the recommended therapeutic dose of the non-prescription medication (see reverse side.) For the safety of the student, a written request from the parent/guardian and licensed medical practitioner is required if the dose is other than the recommended therapeutic dose found on the package label.

Stock medications will not be given in combination with other non prescription medications, e.g. cold medicines as they may have also contain tylenol or ibuprofen.

Only one dose of medication may be administered during the school day.

Stock medications will not be administered for more than three days in a row or eight days per month without documentation from a medical practitioner.

All stock medications are available in tablet form only.

Medication will be administered by staff designated by the school nurse and principal.

This request is in place for the current school year only.

Student _____	Birth Date _____
School _____	Grade _____ School Year _____
has permission to receive:	
<input type="checkbox"/> acetaminophen (Tylenol) OR <input type="checkbox"/> ibuprofen (Advil, Motrin) (Check only one medication.)	
as needed in the health office for complaints of headache, body aches, menstrual cramps, dental discomfort.	
My child's weight is 100 pounds or greater. <input type="checkbox"/> Yes <input type="checkbox"/> No	

Warning: Acetaminophen should not be used by those with liver disease or a hypersensitivity/allergic reaction.

Warning: Ibuprofen should not be used by those with kidney disease, stomach disorders such as bleeding or ulcers, an aspirin allergy or a hypersensitivity/allergic reaction.

I, the parent/guardian of the above named student, request the non-prescription medication listed above be given as needed at school. I agree to hold the School District, its employees and agents who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school. My signature indicates that I have fully read and understand the above information.

Parent Signature _____ **Date** _____

Medication Dosing:

Acetaminophen

Dosing:

Less than 100 pounds	one 325 mg tablet
100 pounds or greater	two 325 mg tablets

Ibuprofen

Dosing:

Less than 100 pounds	one 200 mg tablet
100 pounds or greater	two 200 mg tablets

Medication labels will be provided upon request.