K-6th REQUEST FOR ADMINISTRATION OF MEDICATION

PRESCRIPTION AND OVER-THE-COUNTER

STUDENT INFORMATION

NAME	DATE OF BIRTH (AGE)	GRADE
ADDRESS	CITY	ZIP

STUDENTS IN GRADES K-6TH *MUST HAVE A COMPLETED FORM* ON FILE FOR THE ADMINISTRATION OF *ANY* MEDICATION, INCLUDING TYLENOL AND IBUPROFEN. PARENTS OF PRIMARY STUDENTS *WILL BE CONTACTED* PRIOR TO PAIN RELIEVERS OR FEVER REDUCERS BEING ADMINISTERED.

ADMINISTERING OF IBUPROFEN/TYLENOL

MEDICATION	DOSAGE	TIME/S
Ibuprofen/ Tylenol	Per Age	As Needed, Based On Temperature

☐ I ***DO NOT*** WISH MY CHILD TO BE GIVEN ANY PAIN RELIEVER/FEVER REDUCER

(Only mark the above box if you *DO NOT* wish your child to receive Ibuprofen/Tylenol from the school)

MEDICATION INFORMATION (1)

MEDICATION	DOSAGE	ROUTE	TIME/S

NOTE: Qualified School personnel may give the first a.m. dose at school if necessary.

LENGTH OF TIME MEDICATION WILL BE REQUIRED	
DIAGNOSIS	MEDICAL PROVIDER
ADMINISTRATION INSTRUCTIONS	

TO COMPLY WITH IA ADMINISTRATIVE CODE SECTION 281-41.12(11) ENTITLED "MEDICATION ADMINISTRATION", A DESCRIPTION OF POTENTIAL REACTIONS FROM MEDICATION MUST BE FILED AT THE SCHOOL. **PLEASE LIST ANY ANTICPATED MEDICATION REACTIONS:**

MEDICATION INFORMATION (2)

MEDICATION	DOSAGE	ROUTE	TIME/S

NOTE: Qualified School personnel may give the first a.m. dose at school if necessary.

LENGTH OF TIME MEDICATION WILL BE REQUIRED	
DIAGNOSIS	MEDICAL PROVIDER
ADMINISTRATION INSTRUCTIONS	

TO COMPLY WITH IA ADMINISTRATIVE CODE SECTION 281-41.12(11) ENTITLED "MEDICATION ADMINISTRATION", A DESCRIPTION OF POTENTIAL REACTIONS FROM MEDICATION MUST BE FILED AT THE SCHOOL. **PLEASE LIST ANY ANTICPATED MEDICATION REACTIONS:**

PLEASE SIGN BELOW

I, the guardian of the above named student, request medication be given to the student by the qualified school personnel. In the event of an emergency, I give the qualified school personnel permission to communicate with the school administrator regarding this medication and medical condition.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

SCHOOL PERSONNEL _____ DATE _____

Note: This form must be completed and on file at the school before any medication can be given.