

**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 (2021 – 2022 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**