FAIRFIELD COMMUNITY SCHOOL CORPORATION

MEDICATION REQUEST FORM

Health Services Fairfield Jr.-Sr. High School
67530 US 33 Goshen, IN 46526 Phone: 574-831-2184 FAX: 574-831-2187

If you want your child to receive medication for pain or other reasons, please complete this form and sign and return it to the Nurse's Office. Indiana state laws require that medications can be administered *only* if there is a written/signed request from the student's parent or guardian on file *each* school year. **PLEASE NOTE: For your child's safety, the first dose of any new medication must be given at home, and you must observe for any possible side effects before your child returns to school.**

As parent/guardian of _____Grade_____,
I request that the school administer the following medication/medications to the above named student:

Request for Tylenol/Acetaminophen	Please complete here for other medications
Name of Medication: Tylenol/Acetaminophen 500mg	
Purpose of Medication: Pain Relief	
How much to be given: 1-2 tablets *↓ Maximum of 6 tabs (3,000 mg) per 24 hours	
Time of day to be given: Every 6 hours as needed↑*	
Possible side effect: Liver toxicity if taken in excess	
Number of days to be given: 2020 -2021 School Year	2020 – 2021 School Year
Physician's Name:	**Physician's Name:**

TYLENOL AND ADVIL ARE AVAILABLE IN THE CLINIC FOR OCCASSIONAL USE. **IF THE STUDENT REQUIRES FREQUENT DOSES OF TYLENOL OR ADVIL, OR NEEDS MEDICATIONS OTHER THAN TYLENOL OR ADVIL, THE STUDENT MUST PROVIDE THEIR OWN MEDICATION** IN THE ORIGINAL CONTAINER AND LABELED WITH THE STUDENTS NAME, NAME OF MEDICATION, DOSAGE, AND TIME THE MEDICATION IS TO BE GIVEN**. IF YOUR CHILD CANNOT SWALLOW TABLETS/CAPSULES, YOU WILL NEED TO PROVIDE YOUR OWN LIQUID OR CHEWABLE MEDICATION**. ***ALL MEDICATIONS MUST BE STORED IN THE NURSE'S OFFICE*****.** *Students may not possess medications in back packs or keep medications in their lockers while at school, unless the required forms for emergency use are completed by a physician.* Any unclaimed medication remaining at the end of the school year will be discarded. ***PLEASE NOTE:*** **Administration of medication will not exceed dosage listed on the label without a written statement from a physician.**

This certifies that I, the undersigned parent/guardian am aware of the above authorization and hereby request that assigned school personnel administer the above medication. I certify that my child has no allergy to the above medication, and has had no adverse effect during prior administration of this medication. I agree to notify the nurse immediately of any change in circumstances concerning administration of this medication. I release school personnel from all liability in the carrying out of this procedure.

_____ _____
Date Signature of Parent/Guardian

OFFICE USE ONLY

Date	Time	Medication and Amount	Reason Medication was given	Administered by