**WARREN HILLS REGIONAL SCHOOL DISTRICT**

Health Offices

**Middle School** – 908-689-0750 ext 2020 **High School** – 908-689-3050 ext 2

**MS Fax** – 908-835-0570 **HS Fax** – 908-835-8511

**Tylenol – Tums – Benadryl Administration in School**

The school doctor has provided a standing-order to administer one or two 325mg tablets of Tylenol as needed for menstrual cramps/headache/pain (chewable or liquid Tylenol will also be available). Tums – 2 tablets as needed for stomachache and heartburn. Benadryl – 1-2 tablets as needed for allergies or bee stings/bug bites, ALL with parent written or verbal permission. **\*\*It is the responsibility of the parent to notify the School Nurses IN WRITING if there is a change in their child’s health status which as a result of administration of any of these medications could be detrimental (ie: conflicts with new medications (Tums and certain antibiotics), start taking allergy medication at home on a daily basis (ie: Claritin, Sudafed, etc.).\*\***

 If you want the nurse to administer Tylenol/Tums/Benadryl to your child for the current school year, please complete and sign the form below and have your child return it on the first day of school.

Thank you.

 Sincerely yours,

 Bonita Duryea, RN – High School

 Kristyn Sbriscia, RN – High School

 Michelle Gaffney, RN – Middle School

 Linda Katstra, RN – Middle/ High School

 School Nurses

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Please complete, sign and return to homeroom teacher on the first day of school.

I give permission for the school nurses at Warren Hills Regional School District to administer during the currentschool year.

\_\_\_\_\_\_\_ **Tylenol** 325mg 1-2 tablets (or chewable tablets or liquid) by mouth as needed for

 headache/cramps/pain

\_\_\_\_\_\_\_ **Tums** 2 tablets as needed for stomachache and heartburn

\_\_\_\_\_\_\_ **Benadryl** 1 or 2 tablets as needed for allergies or bee stings/bug bites

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Students Last Name First Name Age Grade

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian Date