Princeton Public Schools

A. I give permission for my _____

(Son/Daughter – PLEASE PRINT NAME)

SCHOOL: _____

1. To receive: **Motrin/Advil/Ibuprofen** (*age & weight appropriate*)
2. To receive: **Tylenol** (*age & weight appropriate*)

*If needed during school hours for: headache, cramps, toothache or general pain.

B. I hear by give permission for the school to arrange emergency treatment for my child.

From: _____ Date: ____/_____/_____

(Parent/Guardian - SIGNATURE)

Please provide a list of medication your child uses daily or as needed.

_____ Inhaler

_____ Epi-Pen

Type of allergy: _____

Medication Used: _____

Contact the School Nurse if medication administration is required during the school day.

Updated as of 11/12/20