



School Year \_\_\_\_\_

### High School Ibuprofen (Advil, Motrin) and Acetaminophen (Tylenol) Authorization Form

Minnesota state law (statute 121A.222) allows students to use nonprescription pain relief in the school setting without a written medical provider order provided the medication is taken in a manner **consistent with the labeling on the medication**. The district must have received a written authorization from the parent or guardian and this authorization must be submitted each school year. Faribault Health Services will require the medication be stored in the original container in the Health Office for students and administered by the Health Office Staff unless the parent/guardian has requested the student to carry and self-administer the below medication. Any more than 5 doses a month, requires a medical providers prescription. Faribault Public Schools do not supply any medication.

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Room/Advisory Teacher \_\_\_\_\_ Grade \_\_\_\_\_

#### Parent/Guardian Authorization

Medication \_\_\_\_\_

Medication is given according to the manufactures labeling on the package.

Reason(s) for use \_\_\_\_\_

I request and authorize trained school staff to administration the above medication during the school day.  
I understand that an adult needs to deliver this unopened medication directly to the health office if not self-administering.

I request and authorize my student to take this medication home at the end of the school year, or when expired.

Yes     No, I will pick this medication up.

#### Self-Administration

Yes - I authorize my student to carry and self-administer the above medication throughout the school year. I understand that school personnel have the final decision in this authorization and can revoke this privilege at any time safety measures are not followed.

No - this medication should be kept in the health office and administered by the health office staff.

**Student** – I understand that I must take the above medication according to the directions on the bottle and I will not share my medication with anyone else.

★ Student Signature: \_\_\_\_\_

★ Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

This form expires the last day of school. All medication not picked up on the last day of school will be destroyed.