COVENTRY PUBLIC SCHOOLS
1700 Main Street, Coventry, CT 06238

☐ Office Use Only

PERMISSION FOR ADMINISTRATION OF ACETAMINOPHEN & DIPHENHYDRAMINE

Parent/Guardian Authorization

Student's Name____ Date of Birth____________ Weight_______

Grade_____ Teacher____________________ Allergies____

Parent Guardian__________________________ Home_________________ Work/Cell___________________

With the direction of our district medical advisor, acetaminophen (e.g. Tylenol) & diphenhydramine (e.g. Benadryl) may be given to a student if needed with parent/guardian authorization. You will be notified in writing or by phone each time your child receives these medications. If the request is inappropriate or if the usage is excessive, the parent/guardian will be notified.

Signing this form indicates no allergy to these medications is known. You agree to notify the school nurse if at any time your child should not be allowed to receive these medications. This permission will be in effect until the end of the school year. For any potentially serious illness or accident, you will be contacted for further recommendations.

I give permission for my child to receive Acetaminophen (e.g. Tylenol) by mouth every four to six hours for the following complaints: menstrual cramps, headache without injury, recent dental work, symptoms of the common cold, minor joint or muscle pain, musculosketal injuries that are under doctor's care, earaches, or fever.

PARENT/GUARDIAN SIGNATURE____ Date______________

I give permission for my child to receive Diphenhydramine (e.g. Benadryl) by mouth every six hours for the following: mild hives, itchy rash or localized reaction to insect bites. ** *Not to be administered for routine allergy treatment.*

PARENT/GUARDIAN SIGNATURE____ Date______________

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