SCHOOL TOWN of MUNSTER
A DISTRICT OF NATIONAL DISTINCTION
SUPPORTING EVERY CHILD EVERY DAY

AUTHORIZATION FOR NON-PRESCRIPTION PAIN MEDICATION

Date: _____ Grade: _____

Student Name: _____

I, the parent/guardian of the above-named student, authorize and give written permission to the school nurse or designated staff to administer the medication below, in accordance with the instructions provided, for pain or discomfort. I agree to notify the school of any change in circumstances concerning the administration of this medication.

Please mark an "X" next to your choice(s) for the student

Ibuprofen 200mg every 6-8 hours as needed

_____one or ____two

Acetaminophen 325mg every 4-6 hours as needed

____one or ____two

Acetaminophen ES 500mg every 6hrs as needed

____one or ____two

Print Parent/Guardian Name_____

Parent/Guardian Signature_____