<u>Dansville High School Health Office</u>

(Fax #: (585) 335-4001)

Grade Level_______

Please allow my child ____________________________, to receive one of the following medications for the 2018-2019 **school year**. This medication
will be given every 4-6 hours as needed. This medication will be given for headaches, menstrual cramps, minor discomfort, orthodontic discomfort and fever. Please check off all medications   **you will allow your child to take at school .**   I understand that the school   nurse, or other designated person (in the absence of the school nurse) will assist my self-directed student in the administration of their medication

NOTE: This form needs parent **<u>AND</u>** health care provider signatures.

_____(2) Regular Strength Acetaminophen (650mg) (Similar to Tylenol)

_____(2) Ibuprofen – total dose of 400mg (Similar to Advil)

_____Cough Drops

_____(1-2) TUMS every 4 hours (no more then 2x in one day)

Students need to have a new sheet signed every year, and will not be able to receive any medication without this sheet signed and returned.

Signature of Family Doctor ______________________Date__________

Signature of Parent/Guardian____________________Date___________

Thank you
 (Please sign and return
High School Nurse
Sarah T. Mehlenbacher RN   DHS 7-12 BLDG
2018-2019   SCHOOL YEAR

Fax: 585-335-4001 Phone: 335-4010 Ext. 1010