LENAPE REGIONAL HIGH SCHOOL DISTRICT MEDICATION FORM

CHEROKEE 856-983-5140 Fax: 856-810-4379 (grades 9 & 10) Fax: 856-810-4378 (grades 11 & 12)	LENAPE 609-654-5111 Fax: 609-714-7808	SENECA 609-268-4600 Fax: 609-268-4389	SEQUOIA 609-268-3700 Fax: 609-268-3726	SHAWNEE 609-654-7544 Fax: 609-654-5611

This order remains in effect during the school day, school sponsored activities, and school sponsored overnight trips.

This form is valid for the current school year.

Student's Name: _____ Birthdate: _____

I give permission for my student, as noted above, to receive any medication initialed below on this form by the Registered Nurse/School Nurse. I understand that generic equivalent medications may be used.

I would like the following medication (s) made available to my child: **(Please Initial)**

_____Acetaminophen (Tylenol) 650mg every 4 hours or 1000mg every 6 hours be given orally as needed for pain or fever.

_____Ibuprofen 200-400mg every 4 hours for pain or fever as needed and not to exceed 600mg in 24 hours.

_____Tums 2 tabs by mouth when necessary for acid indigestion, heartburn, sour stomach or upset stomach.

Administration of this medication is at the nurse's discretion and may not exceed two consecutive days.

I acknowledge that the school district and its employees or agents shall incur no liability as a result of administration of this medication to my child/ward.

PARENT'S/GUARDIAN'S NAME:_____

PARENT'S/GUARDIAN'S SIGNATURE:_____

DATE:_____

STUDENT'S GRADE:_____