



Ipswich Public Schools

Student Health Information

Student's Name: _____ Date of Birth: _____ Grade: _____

Parent/Guardian Name: _____ Contact Number: _____

Health Insurance Carrier: _____ Physician: _____

Permission to Receive Over the Counter Medications

The School Nurse has my permission to administer the following medication:
(check all that apply)

☐ Ibuprofen (Advil, Motrin)	☐ Cough Drops (Grades 6-12)
☐ Tylenol (acetaminophen)	☐ Midol (for menstrual cramps, Grades 6-12)
☐ Calcium Carbonate (Tums), ages 12+	

If your child requires prescription medication during the school day, please contact your school nurse. Certain forms must be completed for medication to be dispensed during school hours.

In the event my child requires emergency medical treatment, I give permission to exchange information with emergency medical personnel and the receiving hospital for the purpose of referral, diagnosis, and treatment.

I HEREBY AUTHORIZE EMERGENCY TREATMENT FOR THE ABOVE NAMED STUDENT.

Signature of Parent/Guardian

Date

Printed Name

**IF THERE HAVE BEEN ANY CHANGES IN YOUR CHILD'S HEALTH, PLEASE
CONTACT THE SCHOOL NURSE**