

## Dansville High School Health Office

(Fax #: (585) 335-4001)

Grade Level \_\_\_\_\_

Please allow my child \_\_\_\_\_, to receive one of the following medications for the 2026-2027 **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 **AND** 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 than 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 \_\_\_\_\_

Please sign and return

High School Nurse

Michelle Osgood RN DHS 7-12 BLDG

2026-2027 SCHOOL YEAR

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