Naugatuck Health Services
Ibuprofen/Tylenol Consent Form

Dear Parents of _____Date of Birth:_____ Grade: _____School year_____

Our school Medical Director, Dr. Rovetto, has given us a standing order which will allow us to administer Tylenol tablets 325mg (1 or 2 tablets Regular strength) only and/or Ibuprofen tablets 200mg (1 or 2 tablets) only to students in grades 7-12 and ONLY in the case of minor headache, cold symptoms, orthodontic discomfort, menstrual discomforts, and/or muscle cramps. This policy should make it easier for students, parents, and nurses. We all know that there are some days when simple Tylenol or Ibuprofen and short rests have made a great difference.
Any student who has a fever of 100.0 or greater will be given the approved medication for comfort but will **still need to be dismissed home** for fever.
Any student receiving acetaminophen and/or ibuprofen via standing order for **3 consecutive days** or **10 doses in a school year** will automatically have the standing order **discontinued**. **Each** medication may be given following these criteria.
To continue acetaminophen and/or ibuprofen therapy, a prescription must be received from the student's primary care provider requesting the medication be continued for a specified period of time and under what circumstances.

Finally, in keeping with the state law, which requires **both** a doctor's signed order and a parent signature in order to administer this medication to your child in school, we must have your written permission to do so each school year-***signed on this form.***

Please complete the form below-sign and have your son/daughter return it to the nurse's office. We can provide the Tylenol or Ibuprofen at the nurse's office, or you can send in your own unopened bottle with your child. If you have any questions, please call the school nurse at 203-720-5440.
Orders as indicated above approved by Dr Rovetto.

Signature on file at the Nurses office
Dr Allyson Rovetto MD_____

The school nurse has permission to administer (**check which medication you want to be given**)

To my Child _____ Date of Birth _____ Gr._____

- ☐ Acetaminophen 325 mg/tablet, 1-2 tabs, once per school day as needed for headache, sore throat, pain or fever ≥ 100.0°

- ☐ Ibuprofen 200 mg/tablet, 1-2 tabs, once per school day as needed for headache, muscle or menstrual cramps, pain or fever ≥ 100.0°

With my permission and in keeping with the school's standing order given by Dr. Rovetto, my child noted above may only have 10 doses of medication chosen above for the entire school year.

By signing this I confirm that my child does not have an allergy to acetaminophen or ibuprofen.

Parent/Guardian Signature:_____, Date:_____