

School Year 2010-2011

Student \_\_\_\_\_ Sex \_\_\_\_\_ DOB 1/1 Grade \_\_\_\_\_

Medication Tylenol/Acetaminophen Dose/Frequency 325-650 mg q 4h Route PO Time(s) Given In School PM Headache

Date(s) Medication Began 8-31-10 Discontinuation Date(s) 6-30-11

Directions: Initial with times of administration; a complete signature and initials of each person administering medications should be included by law.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
September																																
October																																
November																																
December																																
January																																
February																																
March																																
April																																
May																																
June																																

Initial of person administering medication

INIT. NAME INIT. NAME

X: No School (re. Holiday, Week-end, Snow Day, etc.)

A: Absent

N: None Available

F: Field Trip/Special Event

D: Early Dismissal

W: Dose Withheld

O: No Show

Use reverse side for reporting significant information (e.g. observations of medication's effectiveness, adverse reactions, reason for omission, plan to prevent future "no shows".)

Coyle and Cassidy High School  
Nursing Department

REQUEST FORM FOR DISPENSING ACETAMINOPHEN (TYLENOL) AT  
SCHOOL

I request and give my consent to the school nurse to administer acetaminophen (Tylenol) to my child, \_\_\_\_\_ . Grade \_\_\_\_\_ .  
Date of birth \_\_\_\_\_ .

I request and give my consent to the school nurse to give my child acetaminophen (Tylenol) 325 mg to 650 mg for mild pain and/or fever of 100°-101° and 650 mg to 1000 mg for moderate-severe pain and/or fever over 101°. Acetaminophen (Tylenol) may be given every 4 hours as needed.

I request and give my consent to the school nurse to give my child TUMS 2 chewable tablets as needed for epigastric discomfort or complaint of indigestion.

I request and give my consent to the school nurse to apply Calamine lotion, Caladryl lotion, burn cream, Solacaine spray, and antibiotic ointment as needed.

Please list and describe any allergic reactions that your child has experienced:

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Parent /Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_