

School Year

**2011-2012**

Student

Sex

DOB

Grade

Medication

Tylenol

Acetaminophen

325-650 mg q 4h

Time(s) Given In School

Date(s) Medication Began

8-30-11

Discontinuation Date(s)

6-30-12

A.R.

pill headache

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.)	F:	Field Trip/Special Event
_____	_____	_____	_____	A:	Absent	D:	Early Dismissal
_____	_____	_____	_____	N:	None Available	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 \_\_\_\_\_