Confidential

Request to receive Acetaminophen (Tylenol)

Confidential

School Year 20___ /20___

Name of Student: _____ BD:____/____/____

School:_____ Grade: _____

Teacher: _____

Additional Instructions: _____

_____

☐ **I HEREBY GIVE MY PERMISSION** for _____ to receive Acetaminophen (eg. Tylenol) with dosage per package instructions.

☐ Daily ☐ Weekly ☐ Only with phone approval from parent/guardian

For Completion by Parent, an individual who has executed a caretaker relative educational authorization affidavit, or Guardian

As the parent, individual who has executed a caretaker relative educational authorization affidavit, or guardian of the above named student, I confirm that this student has been instructed by his/her health care provider on the proper use of this/these medication(s). He/she has demonstrated to me that he/she understands the proper use of this medication. He/she is physically, mentally, and behaviorally capable to assume this responsibility. He/she has my permission to self medicate as listed above, if needed.

I also acknowledge that the school district may not incur liability as a result of any injury arising from the self-administration of medication by the pupil and that I shall indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional tort.

I agree to also work with the school in establishing a plan for use and storage of backup medication if prescribed, as above, by my child's physician. This will include a predetermined location to keep backup medication to which my child has access in the event of an asthma or anaphylaxis emergency.

Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

I understand that in the event the medication dosage is altered, a new "self-administration form" must be completed.

I understand that the initial dose must be given previously to student by parent or guardian.

_____ **Yes** _____ **No**

I have received, understand and am willing to comply with Sidney Schools Medication Distribution Policy.

_____ **Yes** _____ **No**

Parent/Guardian Signature: _____ Date: _____