

Southington School Health Services
Southington Public Schools

AUTHORIZATION OF A PARENT/ LEGAL GUARDIAN/ ELIGIBLE STUDENT
FOR THE ADMINISTRATION OF IBUPROFEN
OR ASPIRIN SUBSTITUTE CONTAINING ACETAMINOPHEN

Connecticut State Laws and Regulations allow licensed nursing personnel, or in their absence, qualified personnel to administer ibuprofen or an aspirin substitute containing acetaminophen to a student with the written authorization of a parent/ legal guardian/ eligible student (18 years old or emancipated minor) on the form designated for this purpose. These medications are to be provided in the original, unopened, labeled containers and are to be delivered to the nurse by a parent, guardian or other responsible adult. Due to the possible incidence of Reye's Syndrome, **a student's private physician's order is required for the administration of Aspirin.** Ibuprofen should not be given to Aspirin sensitive or allergic individuals. Even though this product contains no Aspirin or Salicylates, a cross reaction may occur. **Ibuprofen may not be given to children under 12 years of age without a private physician's order.**

INFORMATION PROVIDED BY PARENT/LEGAL GUARDIAN/ELIGIBLE STUDENT

Name of Student _____ Grade _____ Date of Request _____

Address _____ Date of Birth _____

Condition for which medication is to be administered _____

Trade Name of medication _____ Generic Name of medication _____

Amount of medication _____

Time and/or frequency of administration _____

History of known allergic reaction to this medication _____

Medication to be administered from _____ to _____
Date *Date*

Medication to accompany student on Field Trips: Yes: No:

Nurse accepting medication _____ Date _____

I hereby request that the above medication be administered by qualified school personnel to my child in accordance with State regulations. I understand that I must supply the school with the above listed medication in the original, unopened, labeled container and will provide no more than a three (3) month supply of this medication.

I also understand that this medication will be properly destroyed if it is not picked up within one week following termination of this request or on the last day of the school year.

Name _____ Relationship to child _____

Address _____ Telephone _____

Signature _____ Date _____