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 delivered to the nurse by a parent, guardian, eligible student or other responsible adult.**

- Parents/guardians should note the expiration date listed on the packaging before supply is dropped off at school.
- Parents/guardians are responsible for replenishing medication supply prior to the expiration date on the container.

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_____
Expiration Date of Medication _____
Amount of medication _____
Time and/or frequency of administration _____
History of known allergic reaction to this medication _____

THIS MEDICATION AUTHORIZATION IS IN EFFECT FOR THE 2023/2024 SCHOOL YEAR
The school year is August 1st through July 31st

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

Nurse accepting medication _____ Date _____

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Parent/Legal Guardian or Eligible Student Authorization

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 understand that I must verify the expiration date prior to bringing this medication to school and will update this medication appropriately.

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 _____