

Kettering City School District
(Elementary and Middle School Use Only)

**PARENT RELEASE FOR A STUDENT TO HAVE ACETAMINOPHEN OR
IBUPROFEN FOR USE DURING THE SCHOOL DAY**

To: _____
(Principal) (Student's Teacher/Unit)

For: _____
(Student's Name) (Date)

Allergies: _____

We (I) the undersigned, who are the parent(s), foster parent(s), guardian(s), (cross out those not applicable) of _____ request that he/she be permitted to have available
(Student Name)

the following medication(s) **until the end of the current school year:**

Acetaminophen (ex. Tylenol) _____ by mouth / g tube
(dosage) (frequency) (circle route)

Ibuprofen (ex. Advil) _____ by mouth / g tube
(dosage) (frequency) (circle route)

- **Over the counter oral medication, for release, refers to medication in liquid, pill or caplet form. Medication may NOT include added medications for sinus, cold, sleep, etc. Dosage cannot exceed manufacturer's dosage recommendations.**

We (I) have reviewed with our/my student the appropriate use of this medication. We (I), the undersigned, agree that the parent(s) will bring acetaminophen/ibuprofen to school in its original container which is properly labeled by the manufacturer to be stored in the school medication cabinet.

We (I) agree to hold the school district and its employees free from any and all responsibility for the results of such medication and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them.

(Parent Signature) (Date)

This acknowledges that the parent understands his/her responsibility in providing the medication in an original container which is properly labeled by the manufacturer. Further, we (I), the undersigned, will notify the school immediately if we change medication or terminate the use of this medication for any reason. When medication has been discontinued, any remaining medication must be picked up by the parent within 2 weeks after discontinuation or it will be discarded by the school nurse. Parent must pick up medication by close of the last day of school or it will be discarded.

Address of parents _____

Home phone _____ Cell phone _____ Business phone _____

To be completed by the school:

School Nurse's Signature **Date**

