**NORTH FOND DU LAC SCHOOL DISTRICT**
**School Health Programs**

Early Learning: 920-929-3762/fax 920-322-9117
Friendship Learning 920-929-3757/fax 920-929-7020
Bessie Allen: 920-929-3754/fax 920-929-3747
Horace Mann: 920-929-3740/fax 920-929-3664

# Consent for Administration of Stock Medication at School

**Student Name:** _____ **Date of Birth:**_____ **Grade:** _____

As a courtesy to our students and family, the District offers stock (over the counter) medication to our middle and high school students. Please check the stock medication(s) you would like available to your student during the school day, the quantity (dose), and the reason to dispense the medication. The stock medication will only be given as directed on the package, and will only be in tablet form.

| MEDICATION | REASON FOR USE |
|---|---|
| ☐ Extra Strength Acetaminophen (Tylenol)<br>☐ 1 tablet = 500mg<br>☐ 2 tablets = 1,000mg | ☐ Headache Other: _____<br>☐ Pain<br>☐ Menstrual Cramps |
| ☐ Ibuprofen (Advil)<br>☐ 1 tablet = 200 mg<br>☐ 2 tablets = 400mg | ☐ Headache Other: _____<br>☐ Pain<br>☐ Menstrual Cramps |
| ☐ Calcium Carbonate (Tums)<br>☐ 1 tablet = 750 mg<br>☐ 2 tablets = 1,500mg | ☐ Indigestion Other: _____<br>☐ Sour/upset stomach<br>☐ Heartburn |
| ☐ Benadryl (Diphenhydramine)<br>☐ 1 tablet = 25mg<br>☐ 2 tablets = 50mg | ☐ Itchy, watery eyes Other: _____<br>☐ Sneezing, runny nose<br>☐ Hives (family will be notified if it this occurs) |

☐ I certify that my child has no known allergies to the above checked medications.
☐ My child is know to be allergic to the following medications: _____

Additional instructions/comments: _____
_____

**As the parent/guardian of the above mentioned student, I will keep the school district aware of any changes in medications or health concerns for my child.** I hereby give permission to designate school district personnel to give medication to my student during the school day. I also give permission to designated school district personnel to notify other appropriate school district personnel and classroom teachers of medication administration and possible adverse effects of the medication. Further agree to hold the North Fond du Lac School District, and the NFDL employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school.

Parent Signature: _____ Date: _____