

**REQUEST TO PROVIDE SCHOOL SUPPLIED MEDICATION:
ACETAMINOPHEN, ANTACID, COUGH DROPS
McCook Public Schools Health Services**

IMPORTANT INFORMATION FOR PARENTS/GUARDIANS:

Your written consent is required *before* your child may receive these SCHOOL SUPPLIED medications at school. Please complete the entire form. By signing below, you acknowledge the following:

- You have reviewed the information and agree that your child may safely take the medications *according to the recommended dose by weight*.
- The school nurse has the responsibility of approving your child's use of these medications.
- Children with fevers of 100.0 or higher must stay home from school until they are fever-free for 24 hours.
- A licensed prescriber's authorization may be required if:
 - Your child requires more than 5 doses of Acetaminophen, Antacid, or Cough Drops in a 30 day period;
 - Your child requires more than 5 consecutive doses of Acetaminophen, Antacid or Cough Drops;
 - In the judgment of the school nurse, your child is ill and not improving.
- Your child's medication may be provided by the nurse or other school personnel determined competent to provide medication as required by Nebraska law.

**WRITTEN PARENTAL CONSENT FOR ACETAMINOPHEN, ANTACID, COUGH DROPS:
MUST BE COMPLETED PRIOR TO MEDICATIONS BEING GIVEN AT SCHOOL.**

I give permission for _____ to receive the following medication:
Student's Name

- Acetaminophen** (generic Tylenol), dose per weight, every 4-6 hours as needed. YES NO
Reason: minor aches and pains
Please notify me when my child takes Acetaminophen at school: YES NO
- Antacid** (Calcium Carbonate), 750mg tab, chewed, every 2 hours as needed. YES NO
Reason: minor stomachache/acid indigestion
Please notify me when my child takes Antacid at school: YES NO
- Cough Drops**, 1 every 2 hours as needed. YES NO
Reason: cough/minor throat irritation
Please notify me when my child takes Cough Drops at school: YES NO

Signature of Parent/Guardian

Date

Phone Numbers: _____