PLAINFIELD HIGH SCHOOL

PARENTAL AUTHORIZATION FOR IBUPROFEN (MOTRIN) AND/OR ACETAMINOPHEN (TYLENOL) BY SCHOOL PERSONNEL

Name of Student: _____ Date of Birth:_____

Address:_____

Student's Personal Physician/Clinic:_____

Name of Parent/Legal Guardian (please print):

_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____

Parental Preference/Dosage: Ibuprofen _____

Acetaminophen _____

I hereby request that the above medication be administered by school personnel. I understand that I must supply the school with my preferred choice of medication, and I'll personally bring medication to the school on behalf of my child.

Parent/Guardian Signature:_____Date:_____

School Year:_____

This form must be completed annually and will only be valid for the current school year.