

**JOHNSON CITY SCHOOLS
HEALTH SERVICES
PERMISSION TO ADMINISTER
Acetaminophen and Ibuprofen for Fever greater than 101.5**

Student's name: _____ Date of birth: _____

School: _____ Grade: _____ School Year: _____

PLEASE CHECK ONE:

- My Student is not allergic to any medications
- My Student IS ALLERGIC to the following medications: _____

List all medication your child takes on a routine basis:

Name of Medication	Dosage	Time to be taken	Purpose

List below any additional health information that the staff should be aware of: _____

Please check the boxes below of the over the counter medication that your child **MAY HAVE** in the event of fever above 101.5.
MEDICATION CHECKED BELOW MUST BE SENT IN A NEW, UNOPENED BOTTLE OR IN A BLISTER PACK THAT IS SEALED AND LABELED.

- ACETAMINOPHEN
- IBUPROFEN

I, the undersigned parent/guardian hereby give permission to Johnson City Schools Staff to administer the checked medications according to the manufacturer's recommendations to my child. I will notify the school nurse of any medications that are given prior to their arrival at school. I also release the Johnson City School System and its personnel from any legal claim they now have or may thereafter have arising from the administration of or failure to administer medication to the student. I will assume full responsibility for any side effects and complications that my child may have as a result of medications.

Custodial Parent/Guardian Signature _____ Date: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Expired Medication cannot be given at school. We do not administer any medications containing SALICYLATE (such as Aspirin and Pepto-Bismol) due to the danger of REYE'S SYNDROME without a written physician's signature. If you have questions, please contact the Office of Health Services at 423-232-5380.