

**RIPON AREA SCHOOL DISTRICT  
2018-2019  
Permission for Administering Stock Medication at School**

Acetaminophen and Ibuprofen are kept in stock **ONLY** at middle and high school levels and are offered as a courtesy to students and parents/guardians. Stock medications will be given as directed on the package and only in tablet form. Parents are highly encouraged to send a personal bottle of the medication if their child will use it frequently during the school year.

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ Birthdate: \_\_\_\_\_

*State Law requires parent/guardian permission before school health staff can provide any stock medication at school.*

Medication	Reason for Use	
<input type="checkbox"/> Acetaminophen (Tylenol) <input type="checkbox"/> 1 tablet = 325mg <input type="checkbox"/> 2 tablets = 650mg	<input type="checkbox"/> Headache <input type="checkbox"/> Pain	<input type="checkbox"/> Menstrual Cramps <input type="checkbox"/> Other _____
<input type="checkbox"/> Extra Strength Acetaminophen (ES Tylenol) <input type="checkbox"/> 1 tablet = 500mg <input type="checkbox"/> 2 tablets = 1000mg	<input type="checkbox"/> Headache <input type="checkbox"/> Pain	<input type="checkbox"/> Menstrual Cramps <input type="checkbox"/> Other _____
<input type="checkbox"/> Ibuprofen (Advil) <input type="checkbox"/> 1 tablet = 200mg <input type="checkbox"/> 2 tablets = 400mg	<input type="checkbox"/> Headache <input type="checkbox"/> Pain	<input type="checkbox"/> Menstrual Cramps <input type="checkbox"/> Other _____

- I certify my child has no known allergies to the above circled medication.
- My child is known to be allergic to the following medications: \_\_\_\_\_
- I am enclosing a bottle of the above circled medication for my child.
- I am supplying the above medication in non-tablet form (chewable, liquid).

Additional Instructions: \_\_\_\_\_

**As the parent or guardian of the above mentioned student, I will keep the school district aware of any changes in medication(s) or health concerns for my child.**

I hereby give permission to designated school personnel to give medication to my child during the school day, including when away from school property on official school business.

I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication.

I further agree to hold the Ripon Area School District, and the RASD employee(s) who is (are) administering the medication, harmless in any or all claims arising from the administration of this medication at school.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

