MIDDLETOWN TOWNSHIP PUBLIC SCHOOLS
Middletown, NJ 07748

Student Name_____Grade_____Date of Birth_____

Medication taken on a regular basis:

_____

I give permission for my child to receive the following medication and will supply the medication:

For headache/earache/menstrual cramps/muscle aches/fever >101 degrees: ***Administered according to weight***

Acetaminophen (TYLENOL) _____YES _____NO

Ibuprofen (ADVIL/MOTRIN) _____YES _____NO

For upset stomach:

Chewable antacid tablets (Tums 1-2 tablets)

_____YES _____NO

For mild allergic reaction:
Administered according to age

Diphenhydramine (Benadryl) _____YES _____NO

I understand that the school nurse, with the established protocol that has been developed and approved by Middletown Township School district physician, can administer the above medications. Be advised that the district shall incur NO liability as a result of any injury arising from the administration of medication and the parents/guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of administration of this medication.

_____ _____ _____

Signature of parent/Guardian Date Contact #