PORTLAND SECONDARY SCHOOLS

Tylenol Permission

Please fill out the top portion of this form if you would like your child to be able to receive Tylenol at school.

I hereby grant permission for my son / daughter to be administered Tylenol (acetaminophen) 650 mg as ordered by the school physician for headaches, cramps or minor aches and pains.

_____ _____

Student Name Grade

_____ _____

Parent Signature Date

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Medication Administration Record

Name of Student		Allergies
Drug: Tylenol	Dose: 650 mg	Route: PO
Time of Administration:		From: To:
Condition for which drug is being administered: headache, cramps, minor aches and pains		
Authorized Prescriber:		Phone: 860-342-7100

Date	Time	Dose	Signature of Nurse/Principal/Teacher	Comments