Chesterfield Elementary School
30 Saddle Way, Chesterfield NJ • Main Office 609.298.6900
Home of the Chesterfield Dragons

Come grow with us!

CONSENT FOR APPROVED MEDICATION (must be completed every school year)

TO BE COMPLETED BY PARENT/GUARDIAN-PLEASE PRINT

SCHOOL YEAR: _______ - ________

Student Name:	Birth Date:

Our school physician has written standing orders for the administration of certain medications to students according to specific guidelines which are listed below. **Medications may NOT be given to any student without parental permission.**

I give permission for my child, ____, to receive the medication checked below if deemed necessary by the Certified School Nurse/School Nurse Substitute. Dosage will be calculated by the dose recommendations already labeled on the medication according to the child's weight and age. I understand that generic equivalent medications may be used.

I would like the following over the counter medication(s) made available to my child: (Please Check)

__________ **Acetaminophen** (like Tylenol)
Acetaminophen will be given for headache or fever 100 degrees or above. The parent will be informed if medication is given. **It is important to note that a child with a fever needs to go home. Parents will continue to be expected to pick up an ill child as soon as possible after a call from the school nurse. Neither school health office is equipped to keep ill children for the duration of a school day.**

__________ **Ibuprofen** (like Advil or Motrin) FOR MENSTRUAL CRAMPS ONLY and will be administered with food or milk.

__________ **Anbesol/Orajel** for toothache

___________ Cough drop for cough or sore throat

__________ I DO NOT want any medication given to my child at school.

Parent/Guardian Signature________________________________ Date_______________