

**Franklin Towne Charter Elementary School**

4259 Richmond Street \* Philadelphia, PA 19137 \* (215) 289-3389 \* (215) 288-4041 (fax)

School Year 2023/2024

Student Name: \_\_\_\_\_ Grade/Room: \_\_\_\_\_ Birth date: \_\_\_\_\_

Medication/Food Allergy(s): \_\_\_\_\_

Medical/health problem(s): \_\_\_\_\_

Medication(s) your child receives at home: \_\_\_\_\_

I give permission for my child to receive any medication checked below as deemed necessary by the school nurse. I understand generic equivalents may be used and this permission will be in effect only for this school year. **My child has previously taken acetaminophen (generic Tylenol)/ibuprofen (generic Advil) without any adverse reaction.**

By signing this form, I give permission for the Health Room staff to share this information with other school staff as necessary.

I would like the following medication(s) made available to my child: (please initial/check)

\_\_\_\_\_ **Acetaminophen** (generic Tylenol) for pain including headache, toothache, menstrual cramps, ect.

\_\_\_\_\_ **\*\*Ibuprofen** (generic Advil) for pain including headache, menstrual cramps, toothaches, sore throat, sprains, and strains. **\*\*For 7th and 8th grade students ONLY, unless ordered by a private physician. \*\***

\_\_\_\_\_ **Tums** for nausea and stomachache

\_\_\_\_\_ **Diphenhydramine** (generic Benadryl) for *severe allergic reactions only – NOT given for allergies*

**\*\*Acetaminophen will NOT be given following a head injury or for fever. It will only be given ONCE during the school day and NOT during the first or last periods of the day. (M-Th 10AM-2PM Friday 10AM-1PM)\*\***

**ABSOLUTELY NO MEDICATION WILL BE GIVEN WITHOUT THIS SIGNED FORM ON FILE IN THE HEALTH ROOM!**

**ALL MEDICATION FORMS MUST BE DATED ON OR AFTER THE FIRST DAY OF THE SCHOOL YEAR.**

I understand that the above medications will be administered by the school nurse in accordance with established protocols developed by the school physician and the school nurse.

\_\_\_\_\_ **I do NOT want any medication given to my child at school.**

Parent Name: \_\_\_\_\_ Parent Signature: \_\_\_\_\_ Date: 8/29/22

Parent Phone #: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_