St. Albert the Great School
104 W. Dorothy Lane
Kettering, OH 45429

PARENT RELEASE FOR A STUDENT TO HAVE ACETAMINOPHEN OR IBUPROFEN FOR USE DURING THE SCHOOL DAY

To: _____ _____
(Principal) (Student's Teacher/Unit)

For: _____ _____
(Student's Name) (Date)

We (I) the undersigned, who are the parent(s), foster parent(s), guardian(s), (cross out those not applicable) of _____ request that he/she be permitted to have available
(Student Name)
the following medication(s) **until the end of the current school year**:

Acetaminophen (Tylenol) _____ _____
(dosage) (frequency)

Ibuprofen (Advil) _____ _____
(dosage) (frequency)

- **Over the counter oral medication, for release, refers to medication in liquid, pill or caplet form. Medication may NOT include added medications for sinus, cold, sleep, etc. *Dosage cannot exceed manufacturer's dosage recommendations.***

We (I) have reviewed with our/my student the appropriate use of this medication. We (I), the undersigned, agree that the parent will bring acetaminophen/ibuprofen to school in its original container which is properly labeled by the manufacturer to be stored in the school medication cabinet.
We (I) agree to hold the school district and its employees free from any and all responsibility for the results of such medication and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them.

_____ _____
(Parent Signature) (Date)

This acknowledges that the parent understands his/her responsibility in providing the medication in an original container which is properly labeled by the manufacturer.

Address of parents_____

Home phone_____ Cell phone _____ Business phone_____

To be completed by the school:

_____ _____
School Nurse's Signature **Date**