MEDICATION FORM

Student's Name_____ Date of Birth_____ Grade_____

Hospital to be called: _____Phone:_____

Doctor to be called: _____Phone:_____

Name of medication: **Ibuprofen 200mg** Dosage: as directed

Time to be taken: **every 6 hours as needed for pain for dental procedure**

Ordering Physician: Dr. Everett, DDS

In case of emergency call: _____

Phone: _____ Cell: _____ Work: _____

I certify that *at least one dose* of the medication has previously been given and NO adverse reactions were experienced. Therefore, I give permission for the school nurse to administer the above medication to my child.

X _____

Parent or Guardian

Dear Parent,

Please sign and return. This gives us permission to give student Ibuprofen for pain relief after a dental procedure ONLY.

Thanks, SBHC staff