



ALL SAINTS ACADEMY

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MAIN CAMPUS
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SPORTS AND ACTIVITY CENTER
11 Day Street, Webster, MA 01570



Website: www.AllSaintsWebster.org

Written Parent / Guardian Authorization For Administration of Tylenol (Acetaminophen) / Motrin (Ibuprofen) Or Non-Prescription Medications

Please provide the OTC medication you are authorizing on this form to the school in its original container.

Student Name: _____

Date of Birth: _____ Grade / Teacher: _____

Parent / Guardian Name(s): _____

Phone Numbers: Home: _____

Work: _____

Cell: _____

My child is currently taking the following medication(s): (Please list both prescription and non-prescription medication) _____

My child has the following allergies: _____

Elementary Students: Tylenol (acetaminophen) dose is calculated by weight.

My child's current weight is _____

Middle School Students: receive the standard recommended dose.

- I give permission to the School Nurse or other trained staff to administer OTC medication to my child, _____, according to the established policy.
- I give permission to the School Nurse to share with appropriate school personnel information relative to medication administration, indications, side effects, etc., as necessary for my child's health & safety.
- I understand that the School Nurse / Staff must speak directly with a parent / guardian prior to each medication administration.

Parent / Guardian Signature _____ Date: _____

Parent / Guardian (Printed Name) _____