SANTA MONICA – MALIBU UNIFIED SCHOOL DISTRICT
1651 Sixteenth Street, Santa Monica, California, 90404-3891
(310) 450-8338
Department of Health Services
School _____ School Year_____

I, the undersigned as legal parent/guardian of _____,
(student's name)

_____
(student's birth date), request that the school nurse make available the following listed medication(s) to my child as prescribed by the district physician consultant. The medication will be given at the school nurse's discretion. (Please indicate which medication you give your permission for by checking below)

Medication	Dose	Route	Time
o Acetaminophen 325mg	1 tablet for student weighing less than 100 pounds 2 tablets for student weighing 100 pounds or greater	by mouth	every 4-6 hours
o Ibuprofen 200mg	1 tablet for student weighing less than 100 pounds 2 tablets for students weighing 100 pounds or greater	by mouth	every 4-6 hours

Other medication taken by this student: _____
_____
_____

List any known allergies _____
_____

_____

Does the student have any sensitivity to aspirin? o yes o no
Does the student have sensitivity to acetaminophen or ibuprofen? o yes o no

List any underlying disease or condition: _____

_____

_____

_____ _____ _____
Date Parent / Guardian signature Parent / Guardian printed name

_____ _____ _____
Home address City zip Work phone Home phone

Please call your school nurse if you have any questions.