COLLIER SCHOOL
160 Conover Rd.
Wickatunk, NJ 07765
732-946-7832 Fax 732-946-6427

Student Name_____Grade_____
Date of Birth_____Allergies_____
Medication taken on a regular basis:_____
_____
_____
_____

I request that the following medications may be administered to my child (**please check medication and circle your child's dose**):

For headache/earache/menstrual cramps/muscle aches/fever >101 degrees:

Acetaminophen (TYLENOL) Regular strength 325mg (1 tab) 650mg (2 tabs)
Extra strength 500mg (1 tab) 1000mg (2tabs)

_____ **Ibuprofen (ADVIL/MOTRIN)** 200mg 400mg

For upset stomach/Circle dose:

____ **Chewable antacid tablets (TUMS)** 1tablet 2tablets

For mild allergic reaction:

____ **BENADRYL:** 25mg 50mg

I understand that the school nurse, with the established orders that have been developed and approved by the Collier School physician along with the written consent of a parent/guardian, can administer the above medications. Be advised that the school shall incur NO liability as a result of any injury arising from the administration of medication and the parents/guardians shall indemnify and hold harmless Collier School and its employees or agents against any claims arising out of administration of this medication.

_____ _____ _____
Signature of parent/Guardian Date Contact #