KIRKWOOD
SCHOOL DISTRICT

**Over-the-Counter Pain Medications**

Date: _____

Dear Parent/Guardian:

During the course of the year, your child might occasionally require the need for pain management for headaches, orthodontic adjustments or muscle soreness. We will administer generic acetaminophen and ibuprofen in tablet or capsule form, only as provided by the school clinic. However, medications of any kind **cannot** be administered **without written consent** from the student's parent or guardian. Dosages will be administered according to label directions.

If you desire to have these over-the-counter medications available to your son or daughter, please complete and sign the permission statement below.

Date: _____

As Parent/Legal Guardian of _____, Grade _____, I hereby give my permission for my child to receive either *acetaminophen* or *ibuprofen* as needed for pain, according to the label directions.

_____ _____
Signature of Parent/Legal Guardian Date

Sincerely,

_____, RN
School Nurse