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HILLEL DAY SCHOOL OF BOCA RATON

PARENTAL PERMISSION FOR MEDICAL TREATMENT 2011-2012

GRADES 1 THROUGH 8 ONLY

Student's Name: ____ Grade: _________ Birthdate: _________

I hereby give permission for my child (named above) to receive the following medication during school hours. I hereby release Hillel Day School and its agents and employees from any and all liability that may result from my child taking the medication.

My child is permitted the following medication treatment. (Please check all medications you wish available to your child.)

____________ Acetaminophen (Tylenol), every four hours, as needed, for pain or fever.

____________ Benadryl Allergy Medication, every four to six hours, as needed, for allergic reactions.

____________ Ibuprofen (Advil, Motrin), every six hours, as needed, for pain or fever.

____________ Antacid, every four hours, as needed, for stomach upset.

____________ Throat Lozenges, every two hours, as needed, for sore throat.

_____ Please contact me before medication is administered. However, if I am unable to be contacted my child may receive the medication according to the recommended guidelines.

____ ______________________________

Signature of Parent Date