AUTHORIZATION FOR DISPENSING MEDICATION
IN SCHOOL OR CAMP

PARENT/GUARDIAN:

I request that my child _____ receive in school/camp administration of Ibuprofen as instructed below and prescribed by:

_____
Physician's Name

_____
Signature of Parent/Guardian

Telephone No. _____ Date _____

PHYSICIAN:

I request that my patient _____receive the following medication:

Name of Medication: Ibuprofen
Diagnosis/Indication: As needed for fever or pain
Prescribed Dosage: ____ mg every 6 to 8 hrs. as needed
Time to be taken during school or camp hours: As needed
Expected duration of treatment: As needed, through the school year or camp session
Possible side effects and adverse reactions: Stomach upset
Other recommendations: Give with food or milk, inform parent of fever, if child looks ill, have seen by health care provider

Print Name: _____ **Tel. No:** 617-323-4440

Signature: _____ **Date:**_____