TYLENOL AUTHORIZATION FORM

Student's Name _____ Birthdate _____ Grade _____

Name of Medication: Tylenol (Or comparable Acetaminophen product) **Dosage**: Two 325 mg (Or less) (Only when requested for pain relief) **Frequency**: Once/day

I confirm that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event my child requests Tylenol (or comparable acetaminophen product) to relieve pain, I hereby authorize the Illini West High School District #307 and its employees and agents, in my behalf and stead, to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of the School District) Tylenol in the manner described above. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF TYLENOL TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I further acknowledge and agree that when the Tylenol is administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said Tylenol.

_____ _____

Parent's Signature Date

Date	Adm By

Date	Adm By

Date	Adm By