



SCHOOL DISTRICT OF WESTFIELD
School Provided Medication Administration Request/Consent Form
For 2025-2026 School Year

Student Name: _____

School: ☐ WMS ☐ WHS

DOB: _____

Grade: _____

As a courtesy, the School District of Westfield will offer stock (school supplied) Acetaminophen and Ibuprofen, as listed below, to middle school and high school students (ages 12 and over) while at school as needed during the current school year.

Parent/guardian consent is needed for students to receive these stock medications.

Stock medication will be administered according to package directions (as stated below).

This consent covers occasional use only, and will be given at the discretion of the school nurse or designated school staff.

Any student that requires any of the listed medications on a regular basis will be asked to provide their own supply of medication and will need a medication consent form filled out by the student's parent/guardian and physician. School supplied medications will not be given to students more than ten times during the school year. If your child reaches the tenth time, a letter will be sent home, alerting you that your child has depleted their doses for the school year.

School supplied medications will only be given to students during the school day; they will not be available on school sponsored trips, athletic events, or after school activities.

Please check the box indicating which medications you authorize your child to receive.

Medications: ☐ Acetaminophen 500 mg tablet - One tablet every 6 hours for headache/pain

☐ Ibuprofen 200 mg tablet - One tablet every 6 hours for headache/pain

PARENT/GUARDIAN REQUEST/CONSENT

I hereby authorize the School District of Westfield (the school nurse or designated school staff) to give the above-checked stock medication(s) to my child according to the directions stated above during the school day. I authorize the School District to contact my child's physician if needed.

I will notify the school nurse/staff of any medications given to my child prior to their arrival at school.

I agree to hold the School District, its employees and agents who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school. I also agree to inform the school immediately, in writing, of any changes to the above consent. My signature indicates I have read and understand the above information.

☐ I certify that my child has no known allergies to the above checked medications. (REQUIRED)

Signature of Parent/Legal Guardian

Print Name

Date

Phone Number

STAFF ONLY:

☐ Age Restriction Checked ☐ Signature Checked ☐ Form sent to Nurse ☐ Med entered in Skyward ☐ Form uploaded to Skyward