

# YORK PUBLIC SCHOOLS

Dear Parent/Guardian:

A Medication Permission Form is to be signed by the parent or guardian and returned to the school if you would like your student to be able to receive Acetaminophen, without you being contacted, for minor health concerns. By signing and returning this form, we will be able to administer Acetaminophen pain reliever to your student for an occasional headache or other mild discomfort. A current form is required for each new school year. Without this form, the school cannot give your student acetaminophen without contacting you for permission. **If this permission form is completed, the school may also provide as needed: generic antibiotic ointment, generic chewable antacid tabs, and generic anti-itch lotion. Please notify the nurse should you NOT want these medications to be given to your student.**

All efforts should be made for students to take routine medication at home. If your student needs to take prescription or non-prescription medication at school, this medication must be brought to the office by an adult. This medication must be in its original packaging and accompanied by the appropriate permission form completed by the parent/guardian as to how/when it should be administered.

A health history questionnaire is located on the reverse side of this form. **Please complete the health history portion and return to the school health office even if you choose not to complete the Acetaminophen permission form.**

If your student has a chronic health condition such as Asthma, Life-Threatening Allergy, Seizures, Diabetes or any other health concern that may impact your student's school day, please contact the nurse by email or phone during the weeks prior to the first day of school so that medical information may be reviewed. This information will assist us in coordinating care for your student during the time that he/she is at school.

Please return this form to the front office at your child's school. If you have any questions, please contact Sue Arnold, RN or Atley Henderson, RN at 402-362-6655.

## ACETAMINOPHEN (TYLENOL) PERMISSION FORM

I give permission to York Public Schools to administer generic acetaminophen (Tylenol) to my child,

\_\_\_\_\_ as needed for occasional discomfort, fever or headache

for this school year, 2025-2026.

\_\_\_\_\_  
Parent / Guardian

\_\_\_\_\_  
Date

# York Public Schools Health History

Student's name \_\_\_\_\_

Sex

Date of birth

Male

Female

/ /

## Student Health Conditions

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> <b>YES</b> , my child receives regular medical/health care for the following conditions: |  | <input type="checkbox"/> <b>NO</b> medical conditions        |
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Seizure disorder                    |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Depression              | <input type="checkbox"/> Sickle cell anemia                  |
| <input type="checkbox"/> ADD/ADHD   | <input type="checkbox"/> Multiple Ear Infections | <input type="checkbox"/> Skin conditions                     |
| <input type="checkbox"/> Autism   | <input type="checkbox"/> Emotional concerns      | <input type="checkbox"/> Speech problems                     |
| <input type="checkbox"/> Behavior concerns  | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Traumatic brain injury              |
| <input type="checkbox"/> Birth/congenital malformations   | <input type="checkbox"/> Heart problems          | <input type="checkbox"/> Uses inhaler/nebulizer              |
| <input type="checkbox"/> Bone/muscle/joint problems   | <input type="checkbox"/> Hemophilia              | <input type="checkbox"/> Vision problems (glasses, contacts) |
| <input type="checkbox"/> Blood problems   | <input type="checkbox"/> Juvenile arthritis      | <input type="checkbox"/> Other _____                         |
| <input type="checkbox"/> Bowel/bladder problems   | <input type="checkbox"/> Nose Bleeds             | <input type="checkbox"/> Other _____                         |
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> Migraines               | <input type="checkbox"/> Other _____                         |
| <input type="checkbox"/> Cystic fibrosis  | <input type="checkbox"/> Neuromuscular disorder  | <input type="checkbox"/> Other _____                         |

Please explain any conditions above or any reasons for hospitalizations.

\_\_\_\_\_

Please indicate any allergies your child may have.

Please list if your child carries/uses an epipen

Allergy type

Reaction

School restrictions or recommended actions

Bee/Insect

Food

Medication

Other

Please list any prescription and over the counter medication that your child takes on a regular basis.

\_\_\_\_\_

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

Yes    No   If YES, please explain.

\_\_\_\_\_

Does the student require any special procedures and/or treatments for their health condition(s)?

Yes    No   If YES, please explain.

\_\_\_\_\_

Child's health insurance:        None           Medicaid/Kid's Connection           Private/Commercial/Employer

Date of last dental exam \_\_\_\_\_ Date of last eye exam \_\_\_\_\_

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

\_\_\_\_\_

**Form Completed by** \_\_\_\_\_ **Relationship to Student** \_\_\_\_\_ **Date** \_\_\_\_\_