



John Witherspoon Middle School

217 Walnut Lane, Princeton, New Jersey 08540 t 609.806.4270

A. I give permission for _____

Daughter/Son

During the school year for 20__ - 20__ GRADE: _____

1. ____ **To receive: Motrin/Advil/Ibuprofen (age and weight appropriate)**
2. ____ **To receive Tylenol (age and weight appropriate)**

If needed during school hours for: headache, cramps, toothache or general pain.

B. I hereby give permission for the school to arrange emergency treatment for my child.

From: _____ Date _____

Parent/Guardian

***Please provide a list of all medications your child uses on a daily or an as needed basis.**

Inhaler _____

Epi-pen _____

Type of allergy: _____

Medications used: _____

Contact the School Nurse if medication administration is required during the school day.

JWMS School Health Office (609) 806-4273