Standing Orders for Medications with Parental Permission

Student Name_____ Grade_____Date of Birth_____
Medication taken on a regular
basis:_____

I request that the following medications may be **administered** to my child.
I will **supply the medication** (please circle 1-4 as desired):

For headache/earache/menstrual cramps/muscle aches/fever >101 degrees:

1. Acetaminophen (TYLENOL) http://www.healthychildren.org/English/tips-tools/symptom-checker/Pages/Acetaminophen-Dosage-Table.aspx?nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+No+local+token

Child's Weight (pounds)	18-23	24-35	36-47	48-59	60-71	72-95	96+	lbs
Syrup: 160 mg/1 teaspoon	3/4	1	1 1/2	2	2 1/2	3	4	tsp
Chewable 80 mg tablets	1 1/2	2	3	4	5	6	8	tabs
Chewable 160 mg tablets	–	1	1 1/2	2	2 1/2	3	4	tabs
Adult 325 mg tablets	–	–	–	1	1	1 1/2	2	tabs
Adult 500 mg tablets	–	–	–	–	–	1	1	tabs

2. Ibuprofen (ADVIL/MOTRIN) http://www.healthychildren.org/English/tips-tools/symptom-checker/Pages/Ibuprofen-Dosage-Table.aspx

Child's Weight (pounds)	18-23	24-35	36-47	48-59	60-71	72-95	96+	lbs
Liquid 100 mg/ 1 teaspoon	¾	1	1½	2	2½	3	4	tsp
Chewable 50 mg tablets	–	2	3	4	5	6	8	tabs
Junior-strength 100 mg tablets	–	–	–	2	2½	3	4	tabs
Adult 200 mg tablets	–	–	–	1	1	1½	2	tabs

For upset stomach:

3. Chewable antacid tablets (Tums) 1-2 tablets

For mild allergic reaction (Circle dose that applies to your child):

4. Diphenhydramine (BENADRYL)
   - Under 6 year of age - 12.5mg (1 teaspoon of 12.5mg/teaspoon)
   - 6-12 Years of age 25 mg (2 teaspoon = 25 mg)
   - >12 years old 25mg-50mg (2-4 teaspoon of 12.5mg/teaspoon)

I understand that the school nurse, with the established protocol that has been developed and approved by Middletown Township School district physician, can administer the above medications. Be advised that the district shall incur NO liability as a result of any injury arising from the administration of medication and the parents/guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of administration of this medication.

_____ _____

Signature of parent/Guardian Date Contact #

MIDDLETOWN TOWNSHIP PUBLIC SCHOOLS

MIDDLETOWN, NJ 07748

MEDICATION PROCEDURE AND PERMISSION FORM

Dear Parent/Guardian/Caretaker and Physician:

Any medication, including all over-the-counter medication, administered by personnel of Middletown Township Public Schools must be accompanied by written orders from a physician. The medication must be in a labeled, prescription bottle with specific instructions. (Pharmacies will provide bottles for school use.) At no time is a student to transport or have in his/her possession any medication.

Student's Name:_____ Birth Date:_____

Address:_____ Phone:_____

School:_____ Teacher:_____

Physician's Authorization:

Medication:_____ Dose:_____

Time or circumstance of administration at school:_____

Duration of administration:_____

Reason for administration:_____

Side effects to be aware of:_____

Any additional instructions or follow-up:_____

Physician's Signature:_____ Date:_____

Parent/Guardian/Caretaker Permission:

Be advised that the district shall incur **NO** liability as a result of any injury arising from the administration of medication and that the parents/guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of administration of this medication.

I give permission to the nurse to administer the above medication to my child.

Parent/Guardian/Caretaker Signature:_____ Date:_____

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6/05