

**Meridian Public Schools
2023-2024**

Parent Permission to use Standing Orders- Medications and Treatments

Student Name: _____

Grade: _____

My child may receive the following medications as needed during the school day:
(Check all that are allowable) – Medications are given as directed on the label for age and weight.

- ___ **Tylenol (Acetaminophen)** – Tablets 325 mg each – Dosage 2 tablets for 12 years old and older
Liquid – Dosed according to age/weight for 11 years old and younger
(May be given every 4 hours as needed for headache, toothache, earache or other pain)
- ___ **Advil/Motrin (Ibuprofen)** – Tablets 200 mg each – Dosage 1-2 tablets for 12 years and older
Liquid – Dosed according to age/width for 11 years old and younger
(May be given every 4 hours as needed for headache, toothache, earache, menstrual cramps, orthopedic injuries or other pain)
- ___ **Benadryl (Diphenhydramine)** – Liquid or tablets – dosed according to age and weight
(May be given every 6 hours as needed for allergic reactions)
- ___ **Tums** – Dosage 1 -2 tablets every 4 hours as needed
(May be given for indigestion, upset stomach, nausea or bloating)
- ___ **Cough Drops** – 1 lozenge every 2 hours as needed *for cough, irritation, pain, sore mouth or sore throat.*
- ___ **Bacitracin/Triple Antibiotic/Burn Cream** – as needed *for superficial wounds/abrasions to prevent infection.*
- ___ **Hydrocortisone Cream or Benadryl (Diphenhydramine) Cream/spray** to affected area every 2 hours as needed *for itching.*
- ___ **Artificial Tears** – 1-2 drops per eye *for redness or itching related to allergies or dry eyes.*
- ___ **Barrier Creams, lotions or other skin protectants** – Examples–Vaseline, Aquaphor, Lip Balms

- ◇ I understand a new form needs to be filled out and signed for each school year.
- ◇ I understand that my child will only be able to receive these medications subject to the availability of the school nurse or other medication - qualified staff member.
- ◇ I understand that First Aid and care for illness and accidents will be provided.

Signature: _____ Date: _____

I would like to be notified of the time my child receives these medications at school.

_____ Yes, by phone # _____
_____ Yes, by email at _____