Meridian Public Schools
2024-2025
Parent Permission to use Standing Orders - Medications and Treatments

The waiver does not carry over from year to year and must be completed annually.

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 _____