

Student's Name: _____

Grade: _____

2021-2022
Standing Orders

A complete copy of Standing Orders/Administration Protocols are available in the Health Office

I hereby authorize the Petersham Center School nurse to:

1. Administer acetaminophen (i.e. Tylenol) according to recommended dosage by age/weight.

Please note: NO medication will be given after 2:30 p.m.

2. Topical agents:

- Bacitracin Ointment for superficial wound care
- Calamine Lotion for contact dermatitis, insect bites, or generalized skin irritations
- Petroleum Jelly (i.e. Vaseline, Aquaphor) for chapped lips or dry skin
- Hand Sanitizer Foam/Gel (70% alcohol)
- Administer antacids in the form of tablets (like Tums), 1-2 tablets every four hours as needed to students complaining of heartburn or upset stomach.

In the event a life threatening allergic reaction (anaphylaxis) should occur to students that have not been previously diagnosed with an allergy (i.e. food or insect bites), epinephrine will be given by auto-injector (EpiPen).

All students must have this written authorization from their parent/guardian to receive these medications. Any other medications other than those listed above (prescription or over-the-counter, including cold medicine, anti-histamines, cough drops, creams/ointments, etc) **WILL NOT** be available or administered *unless prescribed by a physician* and will need to be provided by the parent. Medication will be administered according to the established protocols for administration stated above and state and local policies and procedures. (DPH regulations 105 CMR 210.000)

Please complete all information [check off the appropriate boxes above] and sign below.

PARENTS ARE REMINDED THAT CHILDREN MAY NOT CARRY ANY MEDICATIONS - INCLUDING COUGH DROPS - IN SCHOOL AND SELF MEDICATE without the written approval of their physician, the school nurse and the parent.

Parent/guardian signature _____

Date: _____

Please list any **allergies/medical conditions**, the student's reaction and required treatment:
(All treatments must be accompanied by a physician's order)

Allergy/Condition	Reaction	Treatment

Please list any medical conditions, health concerns and comments not listed above:

Any routine prescription medications being taken: _____

I give permission for the school nurse to share necessary medical information with the staff members responsible for my child at school. Yes. No

Parent/guardian signature _____

Date: _____

Student's Name: _____ Grade: _____

PETERSHAM CENTER SCHOOL

Record DATE, TIME, DOSE, REASON and INTITIAL

Acetaminophen	Other

Initial _____ Nurse's Signature _____
Initial _____ Nurse's Signature _____
Initial _____ Nurse's Signature _____

Initial _____ Nurse's Signature _____
Initial _____ Nurse's Signature _____
Initial _____ Nurse's Signature _____