Dear Parent/Guardians,

The Hope-Page School District #85 requires your consent to administer the over-the counter medications listed below.

ALL OTHER MEDICATIONS (PRESCRIPTION, OVER THE COUNTER, and ALTERNATIVE MEDICINES AND SUPPLEMENTS) require a specific order for your child by a health care provider with prescriptive authority.

# Standing Orders for Students of Hope-Page School District #85

**Acetaminophen Dosage - *Every 4-6 hours as needed***

| **Child's Weight (lbs)** | **24-35** | **36-47** | **48-59** | **60-71** | **71-95** | **96+** |
|---|---|---|---|---|---|---|
| **Chewable 80 mg** | 2 tabs | 3 tabs | 4 tabs | 5 tabs | 6 tabs | 8 tabs |
| **Chewable 160 mg** | 1tab | 1.5 tabs | 2 tabs | 2.5 tabs | 3 tabs | 4 tabs |
| **Adult 325 mg** | NONE | NONE | 1 tab | 1 tab | 1.5 tabs | 2 tabs |
| **Adult 500mg** | NONE | NONE | NONE | NONE | 1 tab | 1 tab |

**Ibuprofen (such as Advil, Motrin, etc.) - *Every 6-8 hours as needed***

| Child's Weight (lbs) | 24-35 | 36-47 | 48-59 | 60-71 | 72-95 | 96+ |
|---|---|---|---|---|---|---|
| **Junior Strength Chewable 100 mg** | 1 tab | 1.5 tabs | 2 tabs | 2.5 tabs | 3 tabs | 4 tabs |
| **Adult 200 mg tablet** | NONE | NONE | 1 tab | 1 tab | 1.5 tabs | 2 tabs |

I give permission for the trained school staff and/or other designee to administer the above medications to:

_______________________________ (Students Name) ________________ (Date of Birth)

My child is allergic to: ___________________________________________________

Parent/Guardian Signature: ________________________ Date: ___________________

Physicians Signature: __________________________________________

Date: ___________________________________

Active for the 2022-2023 School YearI give permission to the Hope-Page School District # medication administration trained staff member to give my child the above-mentioned medications for comfort measures. I further agree to indemnify or hold harmless the Hope-Page School District # and its agents from all claims as a result of any and all acts performed under this authority. I will inform the school if there is a change in any of this information.

Please complete form, have your child's health care provider sign and return all pages to the school

**New form will need to be completed and signed for each school year