# MARSHALL COUNTY SCHOOLS

## Physician Standing Orders to Dispense Non-Prescription Medication(s)

Student Name: _____ DOB: _____ School year_____

**The above student may be administered the following non-prescription medications/preparations on as "as needed" basis at the discretion of the school nurse:**

_____ **Acetaminophen** *(Tylenol)* _____mg every _____ hours for pain or temperature greater than 100 degrees. *(If student has a fever, parent will be contacted and student will be sent home.)*

_____ **Ibuprofen** _____mg every _____ hours for pain or temperature greater than 100 degrees. *(If student has a fever, parent will be contacted and student will be sent home.)*

_____ **Allergy Medicine** (specify:_____): _____mg every _____ hours for nasal stuffiness WITHOUT fever or respiratory distress.

_____ **Throat lozenges/cough drops** as needed for sore throat or cough.

_____ **Tums** One or two tablets every _____ hours for upset stomach WITHOUT fever.

_____ **Calamine Lotion** Apply _____ times per day as needed for minor skin irritation, insect bites, or poison.

_____ **Benadryl Topical** Apply to affected area as needed for minor burns, cuts, scrapes, or skin irritations.

_____ **Burn Cream/Ointment** Apply thin layer to skin as needed for burns.

_____ **Lip balm or Vaseline** Apply as needed to dry, chapped lips.

_____ **Bactine** For minor cuts and scrapes, apply as needed after cleaning area with soap and water.

_____ **Bacitracin Topical Ointment** Apply thin layer to minor cuts, scrapes, burns as needed.

_____ **Sting Kill** Apply topically as needed to stings/bites from bees, wasps, mosquitoes, spiders.

_____ **Other: _____**

**Please Note: All medications must be provided to the school nurse in the original package by the parent/guardian.**

**Physician's Name (please print):_____ Phone: _____**

**Physician's Signature: _____ Date: _____**

I understand that, whenever possible, all medications should be given at home. I give permission for my child to take the above medication(s) at school according to county policy. I also understand and agree that the school nurse may talk with the clinician and his/her staff as well as school personnel regarding student's condition and administration of the medication(s) and its effect.

Parent/guardian signature to approve administration of medication(s): _____

Date: _____ Daytime phone number: _____