

# Standing Orders for Students of Hope-Page School District #85 2024-2025

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.

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

Child's Weight (lbs)	24-35	36-47	48-59	60-71	71-95	96+
<b>Chewable 80 mg</b>	2 tabs	3 tabs	4 tabs	5 tabs	6 tabs	8 tabs
<b>Chewable 160 mg</b>	1 tab	1.5 tabs	2 tabs	2.5 tabs	3 tabs	4 tabs
<b>Adult 325 mg</b>	NONE	NONE	1 tab	1 tab	1.5 tabs	2 tabs
<b>Adult 500mg</b>	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+
<b>Junior Strength Chewable 100 mg</b>	1 tab	1.5 tabs	2 tabs	2.5 tabs	3 tabs	4 tabs
<b>Adult 200 mg tablet</b>	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 **2024-2025** School Year. I give permission to the Hope-Page School District #85 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 #85 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*