

**Permission to Administer Acetaminophen or Ibuprofen
Medication Administration Plan 2017- 2018
To be completed by school nurse and parent.**

Name of student: _____ Date of Birth: _____ Grade: _____

Parent/Guardian Name: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Name of Licensed Prescriber: Dr. Javed Hussain, TEC Campus School Physician

Food/Drug Allergies: _____

Please indicate permission for each medication by checking the box(es):

- | | |
|--|---------------------|
| <input type="checkbox"/> Acetaminophen | Dosage: 325- 650 mg |
| <input type="checkbox"/> Ibuprofen | Dosage: 200- 400 mg |

Duration of Order: one year

Frequency: every 4- 6 hours as needed for c/o headache, pain or menstrual cramps

Route of Administration: By mouth

Specific Directions, e.g., times to be given: PRN Q 4-6 hours

Possible Side Effects, Adverse Reactions: monitor for worsening symptoms, call parents and nurse with any negative changes

Required Storage Conditions: Stored in TEC Campus School Nurses Office

Delegated to (If School has MA State Delegation Permit): Trained TEC Campus High School staff nurses

If Person listed above is not available, back-up plans are as follows (if delegation unavailable):

1. Call TEC nurse; if unable to reach
2. Call Director
3. If unable to reach, call parent
4. Last option call pediatrician for directive

Plans for teaching self administration, if applicable: N/A

Other medications being taken by the student (if not in violation of confidentiality):

Plans for monitoring medication, if needed : notify parents if medication is administered

School Nurse Signature: Kerry Kubera, RN

Date: 9-1-2016

Parent/Guardian Signature: _____ Date: _____

(Physician Standing Order on file.)