the education COOPERATIVE

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Permission to Administer Acetaminophen or Ibuprofen

Medication Administration Plan 2016- 2017

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):

- ☐ Acetaminophen Dosage: 325- 650 mg
- ☐ 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.)