STANDING ORDERS FOR MEDICATION/FIRST AID

1. Hydrogen Peroxide: Apply locally for minor cuts/abrasions.
2. Triple Antibiotic Ointment: Apply locally for minor cuts/abrasions.
3. Medicated First Aid Spray: Apply locally for minor cuts/abrasions, or insect bites.
4. Calamine Lotion: Apply locally for relief of poison ivy, oak or sumac.
5. Caladryl Clear Lotion: Apply locally for relief of poison ivy or minor skin irritations.
6. Sting Kill Swabs: Apply locally for minor insect bites.
7. Water-Jel Burn Jel: Apply locally for minor burns.
8. Sore Throat Spray: Use according to instructions for minor sore throat pain.
9. Cough/Throat Drops: Use as directed to relieve coughing and minor throat pain.
10. Chewable Calcium Carbonate Tabs: Use as directed for relief of upset stomach.
11. Sterile Eye Irrigating Solution: Use as directed for eye discomfort and emergency eyewash.
12. Anbesol or Oragel: Use as directed for minor tooth and gum pain.
13. Acetaminophen: for headaches, toothaches, elevated temperature, & other minor aches & pains.
14. Ibuprofen: for toothaches, elevated temperature, minor aches and pain, and menstrual cramps.
15. Ice/heat packs as indicated for minor injuries, pain, headaches, and menstrual cramps.
16. Epi-pen auto injected: for life-threatening allergic reaction, Anaphylaxis.

Sarah Nikolajsen MD

No medication will be administered without the completion of this form. The first dose of medication will not be administered at school. NO ASPIRIN or PRODUCTS CONTAINING ASPRIN PRODUCTS will be administered at school due to the possibility of Reye's syndrome. A 30-day supply of medication may be kept at school and should be delivered to the health office by the parent/guardian. Any medication, prescription or over-the-counter, delivered in any container in which it was **NOT** purchased will be sent home and **NOT** administered.

PRESCRIPTION MEDICATIONS

Prescription medication must be in the container in which it was purchased, with the current prescription label on the bottle. Upon request, most pharmacies will provide a second bottle for school. A signed statement from a physician must accompany any sample medications to be administered by the school.

OVER-THE-COUNTER MEDICATIONS

Administration of over-the-counter medications will be according to the specific instructions on the manufacturer's label. Any over-the-counter medications must be in the original container and must be supplied by the parent/guardian. A written request by the parent/guardian will be required prior to administration.

SELF-ADMINISTERED MEDICATIONS

Students with chronic health conditions, such as asthma or diabetes, may self-administer medications, provided that conditions set forth by state law have been met. Please contact the school nurse for proper forms.

I hereby give permission to the school nurse or designee to administer the medication that I have supplied according to the above instructions. I give permission for my child to be assessed by the school nurse and to administer medications and treatment as indicated according to the STANDING ORDERS on the back of this form. I hereby agree to hold harmless the Board of Trustees and school personnel administering the treatment or medication necessary from any claim or liability for injury or damages caused as a result of the treatment or medications permitted. I acknowledge that it is my responsibility to inform school personnel of any changes in my child's health condition.

List any allergies to medications:

THIS CONSENT FORM MUST BE COMPLETED, SIGNED & ON FILE IN THE NURSE'S OFFICE FOR ANY STUDENT TO RECEIVE HEALTH SERVICES & TO PARTICIPATE IN EXTRA-CURRICULAR ACTIVITIES.

Parent or guardian: _____ **Date:**
Signature

STUDENT: **Birthdate:** **Grade:**

Teacher:

PLEASE COMPLETE BOTH SIDES OF THIS FORM

SCHOOL HEALTH SERVICES CONSENT FORM

The following services are provided:

1. First aid and minor emergency care
2. Treatment of illness occurring during school
3. Exclusion of students with possible communicable diseases, as required by state law
4. Health screenings: lice K-12; vision and hearing K, 1, 3, 5, 7, and 9; height/weight K-12; and blood pressure 7-12; and scoliosis grades 6-8.
5. Administration of medications at parent request, according to school policy
6. Treatment of chronic illness; i.e., asthma, seizures, and etc., following physician's order
7. Development of emergency plans for special health care needs
8. Instruction on puberty, menstruation, and personal hygiene to fifth grade boys and girls
9. Counseling regarding health problems at home and school
10. Counseling and instruction on nutrition, personal hygiene, injury prevention, safety, drug and alcohol prevention, communicable diseases, infection control, and etc.
11. Release of medical information to another health care agency if needed to help treat your child

Please circle the number of the medications/treatments you **DO NOT** WISH YOUR CHILD TO HAVE ADMINISTERED. If you have any questions or concerns, please contact the school nurse at 463-2261.

This information will help us consider health needs in planning for your child's educational needs. In the past or currently, has your child had any of the following?

☐Y/N☐ Allergies? (Food, insect bites, medicine, pollen, etc)
☐Y/N☐ Asthma?
☐Y/N☐ Behavior or emotional problems?
☐Y/N☐ Bone or muscle problems?
☐Y/N☐ Childhood disease? (Mumps, chicken pox, measles, fifth's disease)
☐Y/N☐ Dental or mouth problems?
☐Y/N☐ Diabetes or hypoglycemia?
☐Y/N☐ Ear or hearing problems?
☐Y/N☐ Eye problems, glasses or contacts?
☐Y/N☐ Frequent colds, ear infections, sore throats?
☐Y/N☐ Frequent headaches or nosebleeds?
☐Y/N☐ Head injuries or concussions?
☐Y/N☐ Heart problems or blood disorders?
☐Y/N☐ High fevers with illness?
☐Y/N☐ Kidney or urinary problems?
☐Y/N☐ Seizures or Epilepsy?
☐Y/N☐ Skin conditions?
☐Y/N☐ Speech problems?
☐Y/N☐ Stomach, intestinal, or bowel problems?

Is there any reason your child should have restrictions to physical activity or P.E.?
Do you have any concerns about your child's general health?
Is your child taking any medication?
REMARKS:

Physician: Phone:

IN CASE OF EMERGENCY & PARENTS CANNOT BE REACHED, CONTACT:

1) Name: Phone:
2) Name: Phone:

In the event the parents cannot be reached in an emergency, the parents are hereby notified that treatment will be selected by the Concordia R-2 School District and the parents assume all financial responsibility for the cost of such treatment.

PLEASE COMPLETE BOTH SIDES OF THIS FORM