DEMAREST MIDDLE SCHOOL
DEMAREST NEW JERSEY

FORM # 5

CHILD'S NAME: _____

TEACHER: _____

For overnight trips our school physician has given the nurse written orders to administer medications to children if needed. The medications ordered by the school physician are the only medications that the school nurse may administer, unless you provide a written order from your own physician for other medications.

If you have already provided the school nurse with a written order from your private physician, the nurse will use that order.

Please read the following orders carefully. Circle the dose for your child #1 or #2

1. TYLENOL 325MG 1 or 2 TABLETS BY MOUTH EVERY 4 HOURS AS NEEDED FOR PAIN/HEADACHE/TEMPERATURE >100. **(Please circle number of tablets for your child to receive. Please note that if you do not specify number of tablets given then the dose will be calculated based on your child's weight. Any student that weighed 96 pounds or more when I took weights earlier in the year will get 2 tablets).**

2. BENADRYL LIQUID 25MG/5CC or 50MG/10 CC BY MOUTH EVERY 4 HOURS AS NEEDED FOR ALLERGY SYMPTOMS. NOT TO EXCEED 6 DOSES IN 24 HOURS. **(Please circle the dose you would want your child to receive. If you do not circle the dose anyone weighing more than 96 pounds when I did screenings earlier in the year will receive 10cc or 50 mg of Benadryl if needed).**

3. TUMS – 2 TABLETS EVERY 6 HOURS AS NEEDED FOR STOMACH UPSET.

I have read the above orders. I give my child _____ permission to receive the above medications as ordered if needed.

Parent Signature: _____

Date: _____

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ALL FORMS MUST BE RETURNED BY WEDNESDAY, MARCH 27th

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