Medication Consent Standing Order Form

The Hopewell Area School District policy for administration of Acetaminophen and/or Ibuprofen via Standing Order is as follows:

- Any student receiving Acetaminophen and/or Ibuprofen via Standing Order for 3 consecutive school days or 10 doses in a school year will automatically have the Standing Order discontinued.
- No medication will be administered without the completion of this form and the signature of the parent/ guardian.
- I give permission for the certified school nurse/licensed health personnel to give the following prescribed medication to my child during school hours.

PLEASE *INITIAL* APPROPRIATE BOX/BOXES:

Student Name: _____ Grade:_____

1. **Acetaminophen** (generic form of Tylenol) ☐
   Time: Once per day as needed **Dosage: 650mg**
   _____
2. **Ibuprofen** (generic form of Advil) ☐
   Time: Once per day as needed **Dosage: 400mg**
   _____
3. **11th Grade Physical Examination Permission** ☐

The PA school health law requires a **MEDICAL EXAMINATION** for children in grade 11. I give permission for my child to be examined by the school physician during his/her grade 11 school year.

My child had a grade 11 physical examination on (date)_____with his/her Private Physician.

Private Physician Name:_____ Phone #_____

- Attach an updated immunization record from physician with recent immunizations received.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

OVER ➡

HOPEWELL AREA SCHOOL DISTRICT HEALTH SERVICES

Health History Form

Student Name:_____ **Grade:** _____
Last First

Parent/Guardian Signature: _____ **Date:**_____

Please check if your child has any of the following conditions:

ADD / ADHD		Hearing / Visual Problems	
Anemia / Bleeding Disorder		Heart Disease	
Asthma		Psychological	
Cerebral Palsy		Scoliosis	
Cystic Fibrosis		Seizure Disorder	
Diabetes		Other (explain)	
Gastrointestinal Problems			

Please list or explain conditions _____

Does your child have any allergies? YES / NO (if yes, list specific allergy and reaction)

▢ Medicines: _____ ▢ Pollens:_____

▢ Food: _____ ▢ Stinging Insects: _____

Does your child take medication? Yes / NO (if yes, please list medication information below)

Medication Name_____ **Dose**_____ **Time**_____

Medication Name _____ **Dose** _____ **Time** _____

Is the medication needed during school hours? YES / NO
**All medications to be given during school hours require a signed parent agreement and a signed physician order sheet.*

Does your child have any restrictions in physical activity? YES / NO (if yes, please list restrictions below)

_____

My child's last vision exam was (date) _____ **Dr.** _____

My child's last physical exam was (date) _____ **Dr.** _____