



Parental Authorization for Standing Order Medications

2026–2027 School Year

(Middle/High School Only)

Student Name: _____

Grade: _____

During the school day, students may occasionally experience minor headaches, muscle aches, menstrual cramps, indigestion, or other non-emergency symptoms. With your permission, the medications listed below may be administered by the Certified School Nurse when clinically appropriate and in accordance with the standing orders of the school physician.

Please check all medications you authorize your student to receive:

- ☐ Acetaminophen (Tylenol) – Pain relief/Fever
- ☐ Ibuprofen (Motrin/Advil) – Pain relief/Inflammation
- ☐ Calcium Carbonate (Tums) – Upset stomach/Heartburn

Age- and weight-appropriate dosages will be administered. Only tablets are stocked in the Health Office. If your student is unable to swallow pills, please contact the Health Office.

Health Information

Does your student have any allergies, medical conditions, or take any medications that may affect their ability to receive the medications listed above?

- ☐ No
- ☐ Yes (Please explain): _____

Parent Notification

- ☐ Please notify me if my student receives a standing order medication.

Preferred Phone: _____ Preferred Email: _____

- ☐ It is NOT necessary to notify me if my student receives a standing order medication.

Parent/Guardian Authorization

I have reviewed my student's allergies, medical conditions, and current medications before signing this authorization. I understand these medications may be administered by the Certified School Nurse in accordance with the standing orders of the school physician. This authorization remains in effect for the 2026–2027 school year unless revoked by me in writing.

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____

Date: _____