ADMINISTRATION OF PAIN MEDICATION BY NURSE

Student's Name______________________________ **DOB** ____________ **Grade** ________

Diagnosis ________Pain____

Date Medication Begins ________________ **Date Medication Ends** __6/18/25_________

Name of Medication___Acetaminophen / Ibuprofen _____________________________

Route___PO______**Frequency** _____AS NEEDED______________

Name of Health Care Provider (PRINT) ___Dr. Mendler -School Physician_____

__as per district standing orders_________ _____2024-2025________
Signature of Health Care Provider **Date**

I authorize the nurse to administer the listed medication to my child who is named in the above section. I understand that the district, school, school nurse, and other employees shall incur no liability as a result of any injury arising from the administration of the listed medication. I will indemnify and hold harmless the district, school, school nurse, and other employees against all claims arising from the administration of the listed medication. I consent to the communication between the school nurse and the prescribing health care provider necessary to ensure the safe administration of the listed medication.

____ ___________________________
Signature of Parent/Guardian **Date**

************<u>**EFFECTIVE FOR ONE (1) SCHOOL YEAR**</u>************