**Kansas State School for the Blind**

**Over the Counter Medication Standing Orders**

**Student Name: Allergies: Medicines:**

**DOB: Weight:**   **Restrictions:**

**MD Specific Orders**

**Fever/Pain Control**

Ibuprofen 200mg tab x \_\_\_ every 4-6 hours

Ibuprofen 100mg/5ml, \_\_\_\_ ml every 6-8 hours

Acetaminophen 325mg tab x \_\_\_ every 4-6 hours

Acetaminophen 160mg/5ml, \_\_\_ml every 4-6 hours

**Cold/Cough**

Robitussin Syrup (any variety) \_\_\_\_\_ml every 4 hours

Suphedrine/Sudafed/Sudogest 30 mg tab x\_\_\_\_ every 4 hrs

Mucinex XR 600 mg tab

**Muscle Aches**

Muscle cream

**Stomach Aches/Diarrhea**

Children’s Mylanta liquid \_\_\_ml every 8 hours

Children’s Mylanta 400 mg tab x \_\_\_ every 8 hours

Imodium AD liquid \_\_\_ml after each loose stool, NTE 45ml/24hr.

Imodium AD 2mg tab x\_\_\_ after each loose stool, NTE 4 tabs/24hr.

Pepto Bismol 400mg Tab x\_\_\_ tabs, NTE 6 tabs/24hr.

**First Aid for Cuts and Scrapes**

Triple antibiotic ointment

Antiseptic spray

**Sore Throat**

Warm Salt Water Gargles

Chloraseptic Spray

Throat Lozenges

**Mouth Sores/Toothaches**

Anbesol/Kanka

Antiseptic Oral Cleanser

**Ear Wax Removal Aid**

Debrox/Carbamide Peroxide 6.5%

**Eye Drops/Lubricants**

**Insect Bites/Stings**

Benadryl 12.5mg/5 ml x \_\_ml every 4 hours

Benadryl 25 mg x \_\_\_ every 4 hours

Benadryl Topical Gel/Cream every 4 hours

Hydrocortisone cream 0.5% or 1% every 6 hours

Calamine Lotion as needed

**Sunburn**

Sunscreen lotion

Solarcaine

Aloe Vera Gel

**Athlete’s Foot/Fungal Infections**

Tinactin Cream/Powder

Monistat Cream

**All OTC’s given per specific package instructions according to weight and age of student and for a reason on the packaging. Nurse may request parent to provide OTC for their individual child’s use. Parental permission:** I give permission to the nursing staff of KSSB, or their delegated proxy, to administer any of the meds on the above OTC list for my child while at school or a school-sponsored event. (Parent, please cross off OTC’s not wanting child to have). **Student resides in dorm during week \_\_\_Yes \_\_\_\_No**

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**Signature of Parent or Guardian Date**

**(Recommended) Physician Order:** The student may take OTC’s listed above, or their equivalent med (generic/name brand), unless it is crossed off. Medication is administered based on package directions and the student’s weight/age unless specifically ordered per physician.

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**Physician’s Signature Date**