



Pillar High School

71-77 Okner Parkway
Livingston, NJ 07039

(973) 535-1999
Fax: (973) 535-1268
Website: www.pillarnj.org

Parental Permission for Standing Orders 2026-2027 School Year

Dear Parents/Guardians,

Below is a list of over-the-counter medications that are permitted within our school standing orders for basic first aid and emergency treatments. Please carefully review the statements below to grant or deny permission for our nurses to provide these treatments for your child. **Please review and sign both pages 1 and 2 of this form.** The school health office can be contacted at **(973) 535-1999 option 3** with any questions or concerns.

Student's Name: _____

Date of Birth: _____

TOPICAL TREATMENTS

1. I give permission for a **Medicated Relief Swab** (containing Benzocaine &/or L-menthol) to be used for temporary relief of pain and itching associated by insect bites and stings. YES _____ NO _____
2. I give permission for topical **Lidocaine Spray/Gel** (solarcaine or burn gel) **or a first aid burn cream** to be applied to minor burns (first degree only) as appropriate, including sunburn. YES _____ NO _____
3. I give permission for topical **antibiotic ointment** (Neosporin or Bacitracin) to be applied to superficial abrasions or wounds with open skin. YES _____ NO _____
4. I give permission for **Orajel** topical oral anesthetic to be applied for a toothache. YES _____ NO _____
5. I give permission for **Caladryl** or **Calamine Lotion** to be applied for itchy poison ivy or contact dermatitis. YES _____ NO _____
6. I give permission for a **diaper rash barrier cream** to be applied for mild rash/reddened skin in diaper area. YES _____ NO _____
7. I give permission for **sunscreen (spray or cream)** to be applied to prevent sunburn on exposed skin as needed. YES _____ NO _____
8. I give permission for **lip balm** and/or an **unscented moisturizer** to be applied for dry chapped lips and skin. YES _____ NO _____

Parent/Guardian Name (Print)

Parent/Guardian Signature

Relationship

Date

Student's Name: _____

Date of Birth: _____

ORAL/ENTERAL MEDICATIONS & TREATMENTS
2026-2027 School Year

Does your child require dye-free oral medication due to a dye-allergy or intolerance? YES _____ NO _____

1. I give permission for **Diphenhydramine (Benadryl)** to be administered for a minor allergic reaction, involving symptoms such as hives or itchy rash with no respiratory or circulatory involvement. YES _____ NO _____
******If your child has a known allergy to Benadryl (diphenhydramine), please have your child's physician write a prescription for a different oral antihistamine that your child is able to tolerate.******

2. I give permission for **Acetaminophen (Tylenol) or Ibuprofen (Motrin or Advil)** to be given for a temperature of 100.4°F or higher according to package dosing instructions for weight. YES _____ NO _____
******Please note that parents/guardians are required to pick students up from school for fever (body temperature of 100.4°F or greater) even if Acetaminophen or Ibuprofen has been administered by a school nurse. Students are not permitted to ride the school bus home with a body temperature greater than or equal to 100.4°F. In the event that the student's temperature remains 100.4°F or above and a parent/guardian is unable to pick the student up from school, 911 emergency services will be called and the student will be transported to the nearest hospital. This is done to ensure the medical safety of your child. Fever-reducing medication will only be given by the school nurses for body temperatures 100.4°F or greater. If your child requires Acetaminophen or Ibuprofen to be given for a temperature lower than 100.4°F, at an "extra strength" dosage, or for any other purposes (i.e. pain), please have your child's physician write a prescription indicating the specific dosage and temperature for which the medication should be given and send in an individual supply of the ordered medication for your child.******

3. I give permission for **Oral Suctioning using a Yankauer Suction Tip** to be performed on my child for thick or excessive oral secretions that are compromising his/her airway. YES _____ NO _____

Parent/Guardian Name (Print)

Parent/Guardian (Signature)

Relationship

Date