LeafSpring™ SCHOOL

Dosing Schedule Authorization

Required for children under two years of age

CHILD'S NAME _____ DATE _____

DOSING AUTHORIZATION: Acetaminophen/Ibuprofen may be administered if my child has a temperature greater than 101º, a headache or teething pain. I authorize the nurse to administer acetaminophen every 4-6 hours and ibuprofen every 6-8 hours, according to the dosage schedule below and as approved by my child's physician. I understand that I will be called before my child is medicated. I further authorize the use of Antibiotic Ointment/Cream, Hydrocortisone Cream, and Sunscreen as indicated below.

I understand that the dosing preferences below **must be completed and signed by my child's physician** since the manufacturer's dosing schedule does not generally include dosing for children under two years of age. I understand that my child's weight will be the default for the correct dosing.

AGE	WEIGHT (pounds)	ACETAMINOPHEN: Elixer (160mg/tsp)	IBUPROFEN: Elixer (100mg / tsp)	Antibiotic Ointment/Cream (Neosporin)	Hydrocortisone Cream	Hypoallergenic Sunscreen (Rocky Mountain SPF 30)
0-6 months	6-11 lbs.	Physician's recommended dosage: _____ mg / _____ tsp or _____ not recommended	Not recommended	Authorized: ☐ Yes ☐ No Frequency: Maximum ___ / daily Other: _____	Authorized: ☐ Yes ☐ No Frequency: Maximum ___ / daily Other: _____	Authorized: ☐ Yes ☐ No Frequency: Maximum ___ / daily Other: _____
7-11 months	12-17 lbs.	☐ 80 mg or ½ tsp ☐ Other: _____	☐ 50 mg or ½ tsp ☐ Other: _____	Authorized: ☐ Yes ☐ No Frequency: Maximum ___ / daily Other: _____	Authorized: ☐ Yes ☐ No Frequency: Maximum ___ / daily Other: _____	Authorized: ☐ Yes ☐ No Frequency: Maximum ___ / daily Other: _____
12-23 months	18-23 lbs.	☐ 120 mg or ¾ tsp ☐ Other: _____	☐ 75 mg or ¾ tsp ☐ Other: _____	Authorized: ☐ Yes ☐ No Frequency: Maximum ___ / daily Other: _____	Authorized: ☐ Yes ☐ No Frequency: Maximum ___ / daily Other: _____	Authorized: ☐ Yes ☐ No Frequency: Maximum ___ / daily Other: _____
Weight 24-35 lbs., even if under 2 years		☐ 160 mg or 1 tsp ☐ Other: _____	☐ 100 mg or 1 tsp ☐ Other: _____	Authorized: ☐ Yes ☐ No Frequency: Maximum ___ / daily Other: _____	Authorized: ☐ Yes ☐ No Frequency: Maximum ___ / daily Other: _____	Authorized: ☐ Yes ☐ No Frequency: Maximum ___ / daily Other: _____

Please note any known side effects or adverse reactions to any of the above medications: _____

_____

Parent Authorization: _____ _____

PARENT SIGNATURE DATE

Physician Authorization:

I have completed my recommendations for the above dosing amounts and approve this dosing schedule for the child named.

_____ _____

PHYSICIAN'S SIGNATURE DATE

_____ _____

PHYSICIAN'S NAME PRACTICE