ANNE GRADY RESPITE DEPARTMENT
1525 EBER ROAD
HOLLAND, OHIO 43528
419-866-6500

RESPITE SERVICES APPLICATION

Upon completion of this application, you will be contacted by a representative of Noah's House/Adult Respite. An appointment and tour will be set up at that time. This process will take approximately one hour. Should you have any questions or concerns, please feel free to contact us.

Application Date:__________
Person/Agency Responsible for Referral:____
Valid Email Address:__________________@______.____
Address:___________________________________ Phone:____________________________

Reason for Respite:____

I. **IDENTIFICATION:**

Name of Applicant:__________________________________ Date of Birth:__________________

Address:____County of Residence:__________________

City: ____________________ State:_____ Zip Code:__________

Phone:_________________________________ Other phone:____________________________

Race:____________ Religion:____________ Sex:__________ Hair Color:_____________

Eye Color:________ Height:_________ Weight:_________ Language:______________

Identifying marks:____

II. **SUPPORTIVE RELATIONSHIPS:**

A. Father's name:________________________________ Birthdate:____________________

Address:___________________________________ Phone:_________________________

Employed by:________________________________ Phone:_________________________

Employer address:____

B. Mother's name:_______________________________ Birthdate:____________________

Address:___________________________________ Phone:_________________________

Employed by:________________________________ Phone:_________________________

Employer address:____

C. Parent's Marital Status:___Married ___ Single ___ Widowed ___ Divorced ___

D. Legal Guardian:____

Valid Email Address:__________________@______.____

E. Emergency contacts:

Name:____ Relationship:___________________

Address:____

Phone:______________________________ Other phone:___________________________

F. Emergency Contacts (continued):

Name:______________________ Relationship:______________

Address:____

Phone:____________________ Other phone:________________

Name:______________________ Relationship:______________

Address:____

Phone:____________________ Other phone:________________

G. Next of Kin not listed above:

Name:______________________ Relationship:______________

Residence:__________________Phone:________________

Name:______________________ Relationship:______________

Residence:__________________Phone:________________

Name:______________________ Relationship:______________

Residence:__________________Phone:________________

III. FINANCIAL:

________ SSI - Amount ____________ ________ SSA - Amount ____________

________ Waiver - Name ____________ ________ Other - ____________

Medicare #:____________________ Medicaid #:____________________

Insurance: ____

Funding Source For Respite: ____________________________

Social Security #: ______________ Name of SASS: ______________

Other Applicable Caseworker: ___________________________

Please attach a current copy of all insurance cards

IV. MEDICAL:

A. Diagnosis/Condition:________________________________

____

B. Past Surgeries: ________________________________

____

C. Medications/Treatments:____________________________

____

C. Special Medical Equipment:__________________________

____

D. Allergies:_______________________________________

____

E. Physical Limitations:____

____

F. Name of Primary Care Physician:______________________________________

Address:______________________________ Phone:____________________

H. Hospital Of Choice: ____

I. Date of Last Tetanus Shot: ____

J. Has the applicant been hospitalized in the past 12 months? YES OR NO

K. Medical Assessment:
Please answer Yes or No to the following questions:

1. Is the applicant able to identify medication(s)? ___________
2. Is the applicant able to indicate why he/she takes medication? Example: for seizures, I get upset easily. _________
3. Can the applicant correctly indicates dose of medication? Example: 25mg, 1 pill, 1 of these little cups filled up to this line. _________
4. Can the applicant indicate health changes or when not feeling well? Example: taking a new pill and now my stomach hurts. ____________
5. Is the applicant able to indicate what to do when meds are low? Example: ask staff, go to pharmacy. ___________
6. Is the applicant able to indicate what time to take medications either by clock or related to a specific routine in day. Example: after breakfast, before bedtime, 8am. __________
7. Is the applicant physically able to get medications(s) from storage, get medication(s) out of container, and physically take or apply medication? ______________

V. **DEVELOPMENTAL ABILITIES:**

Ambulation/Mobility:

______ walks alone
______ walks with assistance
______ sits alone
______ sits with support in special chair
______ crawls/moves around on floor
______ uses walker/crutches
______ uses wheelchair/moves independently
______ uses wheelchair needs assistance

Eating:

______ drinks independently
______ drinks from cup with assistance
______ eats independently with utensils
______ eats using fingers/hands
______ eats with assistance
______ needs to be fed
______ chews, eats regular food
______ needs special diet – Explain:__________________________________

____

______ fed by other than oral means – Explain:____________________________

____

Toileting:

______	uses bathroom independently	______	able to use bathroom during night
______	indicates need to use bathroom	______	wipes independently
______	incontinent - wears diapers	______	needs assistance with wiping
______	able to use bathroom during day	______	uses urinal / bedpan
______	constipation is a problem	Other:_________________________	

Dressing:

______	dresses independently	______	needs assistance with fasteners
______	dresses with assistance	______	needs complete assistance

Personal Hygiene:

______	bathes/showers independently	______	needs assistance with bathing/showering
______	brushes teeth independently	______	needs assistance with tooth brushing

Communication:

______	uses speech to communicate	______	gestures/vocalizes
______	uses some words/phrases	______	uses a communication board or device
______	understands simple requests	______	no effective communication

Sleeping:

______	sleeps in bed with side rails	______	sleeps through night
______	sleeps in bed	______	does not sleep through night

What supervision level does the applicant need in their own home. Please circle one:

the kitchen: visual 5 minute checks 10 minute checks 15 minute checks 30 minute checks
the living area: visual 5 minute checks 10 minute checks 15 minute checks 30 minute checks
the bathroom: visual 5 minute checks 10 minute checks 15 minute checks 30 minute checks
while sleeping: 30 minute checks 1 hour checks 2 hour checks

VI. **BEHAVIORAL CONCERNS:**

Does applicant have any of the following behavioral concerns?

______	aggression	______	self-injury
______	elopement (leaving the area)	______	other behavioral issues
_______	sexual deviance	_______	property destruction

If you marked any of the above, please explain applicant's behavioral concerns, frequency, and intensity, as well as any interventions used.

Frequency: Daily_______ Weekly_______ Monthly_______

Intensity: Moderate_____ Mild________ Severe_______

Describe:____
____
____
____
____

Does applicant have a behavior program in place? ________ Yes ______ No
If yes, what is the name of the Behavior Support Specialist:_____________________

VII. **OTHER:**

A. What does applicant do during normal course of day?_______________________________

____

B. Does applicant attend school, day program, camp? If so, please include name, location, and drop off and pick up times:____

____

C. What are some of the applicant's likes/favorite activities?____________________________

____

D. Dislikes:____

E. Does the applicant like to swim? ______ Are they able to swim? _______

Are they able to use swimming pool and spa?_______________________
Do they need a life jacket?_______________

F. When and how often is applicant in need of respite services?

______ Weekday Comments:______________________________________

______ Weeknights Comments:______________________________________

______ Weekends Comments:______________________________________

______ Emergency Comments:______________________________________

______ Vacation/Week stays Comments:______________________________________

______ Other ____

G. When is the best time to contact you to schedule a tour and/or an appointment?_________

____

H. How did you hear about Anne Grady's respite program?____________________________

____

Please note any additional information that you think would be helpful for us to know to provide services to the applicant.

____
____
____
____
____
____

ANNE GRADY SERVICES
1525 Eber Rd
Holland OH 43528
Phone: 419-866-6500
Fax 419-866-7457

PRE-ADMISSION MEDICAL EXAM
MUST BE SIGNED BY A PHYSICIAN

SECTION A.

General Information

Name:	**Date:**
Age:	**Height:**
Birthdate:	**Weight:**
Tempature:	**Pulse:**
Respirations:	**Blood Pressure:**

SECTION B.

Medications/Diet/Code Status

*If you attach a medication list, it must have a physician's signature on it.

MEDICATION	DOSAGE	TIMES MEDICATION IS GIVEN

Please indicate the type of diet this person in on and any diet restrictions. (If this person receives tube feedings please indicate specific orders feedings):

*Please attach DNR paperwork if you have circled any DNR codes.

Please circle one: Full Code DNR-Arrest DNRCC

SECTION C.

Medical History

SURGERIES	DATE	PROCEDURES	DATE

HOSPITALIZATIONS	DATE

ALLERGIES

SECTION D.

Exam

Head and Neck	
Eyes	
Ears	
Nose	
Mouth and Throat	
Chest	
Breast	
Cardiovascular	
Lungs	
Genitalia	
Back	
Extermities	
Skin	
Neuro	
Station and Gait	

SECTION E.

IMMUNIZATIONS	Date Given
Chicken Pox Vaccine	
Polio Vaccine	
MMR	
Flu Vaccine	
DPT	
PNEUM Vaccine	

A 2-step PPD is required prior to admission or a negative read chest x-ray. A 1-Step PPD is required annually after admission. If a chest x-ray is completed, it must be done every 2 years to avoid interruption of services:

Date of step 1: ____________ Results: ___________MM Date of step 2: _______________Results: ___________MM

Or recent chest x-ray results: ____

Physician's name (please print): ____

Address: ____

Emergency Room of Choice: ____

***Attachments submitted with this form must include a physician's signature.**

Physician Signature:

X ____ Date: ________________________

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TWO STEP MANTOUX (PPD)

Please make sure that your child's TB test is current. Your child will need a current TB test completed within 3 months prior to admission or a negative chest x-ray. A 2 step TB test is required for new respite individuals unless you have record of three consecutive annual TB tests in which most recent must be within the last three months.

Name of Individual: ____

1st step:
Date given: ____
Date Read: ____
Results: ____

2nd step:
Date given: ____
Date Read: ____
Results: ____

Chest x-ray if applicable
Date:____
Please attach copy of results.

Physician/Nurse Signature:
X____ Date: _______________

ANNE GRADY SERVICES
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ADMISSION PHYSICIAN ORDERS

(Not needed for new admissions)
*Needs Updated every 60 days and when every medication changes occur

Name:_________________________Date:___________________

Physician Name:____

Physician Office Phone Number______________ Physician Fax Number________________

Physician Contact Number After Hours ___________________

Physician Address:____

Expected Length of Stay:_________________________

Code Status (Please circle one): Full Code DNR-CC DNR-Arrest
*If none is circled, will assume full code. If DNR-CC or DNR-Arrest please send documentation

Allergies:____
Medications/Treatments (Please include dosage, time of day and number of times per day):

____

____

____

____

**If a medication list is attached, it must have a physician signature and be submitted with this form.

Diet Orders:____

PRN Medication Orders (Please include dosage, time of day and number of times per day):

____

____

____

Emergency Room of Choice:_______________________________________

_____________________________ _____________________________
Physician Signature Date Nurse Signature Receiving Order Date

ANNE GRADY SERVICE
1525 EBER RD.
HOLLAND, OH
PHONE: 419-866-6500
FAX: 419-866-7457

Individuals Name: ___________________________________

Legal Guardians Name: _______________________________

***The guardian must provide their initials in each section in order for this form to be complete.**
***This form is valid for one year from the signature date.**
*** This form must be updated annually to avoid an interruption of services.**

SECTION A: CONSENT TO TREAT

_______I give permission to the authorities of Anne Grady Services and/or St. Luke's Hospital or other medical facilities to render medical services or treatment necessary to the above named person. Such services or treatment may include x-rays, laboratory procedures, and administration of medications, treatment of physical condition, emergency room care, emergency admission, and outpatient care considered essential for the person's condition, illness, or trauma.

(A copy of this form is acceptable to the undersigned as consent to treat)

SECTION B: CONSENT TO TRANSPORT

_________I authorize Anne Grady Services to provide transportation medical treatment, recreational, social, or other programmatic reasons while ________________________is living at Anne Grady Center.

SECTION C: AUTHORIZATION TO OBTAIN/RELEASE AUDIO-VISUAL INFORMATION

_______I authorize Anne Grady Services to make motion pictures, video tapes, photographs, audio tapes, photographs, audio tapes, or press releases. I authorize the public use of this material as deemed appropriate by Annie's House for educational and promotional purposes.

______ I DO NOT authorize Anne Grady Services to make motion pictures, video tapes, photographs, audio tapes, or press releases involving

____ ___________________________________

GUARDIAN SIGNATURE DATE

ANNE GRADY SERVICES
1525 Eber Rd
Holland OH 43528
Phone: 419-866-6500
Fax 419-866-7457

RESPITE DEPARTMENT
INDIVIDUAL RIGHTS

Individuals Name:_____________________

In accordance with Section 5123.62 of the Revised Code, Anne Grady Services is informing you of the rights of persons with mental retardation and developmental disabilities. The rights include, but are not limited to the following:

(A) The right to be treated at all times with courtesy and respect and with full recognition of their dignity and individuality;
(B) The right to an appropriate, safe, and sanitary living environment that complies with local, state, and federal standards and recognizes the persons' need for privacy and independence;
(C) The right to food adequate to meet accepted standards of nutrition;
(D) The right to practice the religion of their choice or to abstain from the practice of religion;
(E) The right to timely access to appropriate medical or dental treatment;
(F) The right of access to necessary ancillary services including, but not limited to, occupational therapy, physical therapy, speech therapy, and behavioral modification and other psychological services;
(G) The right to receive appropriate care and treatment in the least intrusive manner;
(H) The right to privacy, including both periods of privacy and places of privacy;
(I) The right to communicate freely with persons of their choice in any reasonable manner they choose;
(J) The right to ownership and use of personal possessions so as to maintain individuality and personal dignity;
(K) The right to social interaction with members of either sex;
(L) The right of access to opportunities that enable individuals to develop their full human potential;
(M) The right to pursue vocational opportunities that will promote and enhance economic independence;
(N) The right to be treated equally as citizens under the law;
(O) The right to be free from emotional, psychological, and physical abuse;
(P) The right to participate in appropriate programs of education, training, social development, and habilitation and in programs of reasonable recreation;
(Q) The right to participate in decisions that affect their lives;
(R) The right to select a parent or advocate to act on their behalf;
(S) The right to manage their personal financial affairs, based on individual ability to do so;
(T) The right to confidential treatment of all information in their personal and medical records;
(U) The right to voice grievances and recommend changes in policies and services without restraint, interference, coercion, discrimination, or reprisal;
(V) The right to be free from unnecessary chemical or physical restraints;
(W) The right to participate in the political process;
(X) The right to refuse to participate in medical, psychological, or other research or experiments.

It should be understood rights can be exercised within reason and in doing so may not infringe upon the rights of others.

I have been informed of the above rights and have received a copy of these rights and the guidelines for reporting violations of rights at the Anne Grady Services. I have acknowledged being informed and receiving copies by signing the appropriate section, either A or B.

A. As guardian of the above named individual, I have been informed of his/her rights.

______________________________ ________________
Guardian/Parent Date

B. The above named individual at this time is unable to fully comprehend his/her rights. Services are being monitored by his/her Program/Home Coordinator. There is no parent or guardian who can legally sign on this individual's behalf.

______________________________ ________________
Program/Home Coordinator Signature Date

(This information should be kept by the person who has been informed of the rights. Please do not submit this copy with the application)

State of Ohio
THE RIGHTS OF MENTALLY RETARDED OR DEVELOPMENTALLY DISABLED PERSONS
(Ohio Revised Code Section 5123.62)

Sec 5123.62 THE RIGHTS OF MENTALLY RETARDED PERSONS AND OF DEVELOPMENTALLY DISABLED PERSONS INCLUDE, BUT ARE NOT LIMITED TO:

(A) The right to be treated at all times with courtesy and respect and with full recognition of their dignity and individuality;
(B) The right to an appropriate, safe, and sanitary living environment that complies with local, state, and federal standards and recognizes the persons' need for privacy and independence;
(C) The right to food adequate to meet accepted standards of nutrition;
(D) The right to practice the religion of their choice or to abstain from the practice of religion;
(E) The right to timely access to appropriate medical or dental treatment;
(F) The right of access to necessary ancillary services including, but not limited to, occupational therapy, physical therapy, speech therapy, and behavioral modification and other psychological services;
(G) The right to receive appropriate care and treatment in the least intrusive manner;
(H) The right to privacy, including both periods of privacy and places of privacy;
(I) The right to communicate freely with persons of their choice in any reasonable manner they choose;
(J) The right to ownership and use of personal possessions so as to maintain individuality and personal dignity;
(K) The right to social interaction with members of either sex;
(L) The right of access to opportunities that enable individuals to develop their full human potential;
(M) The right to pursue vocational opportunities that will promote and enhance economic independence;
(N) The right to be treated equally as citizens under the law;
(O) The right to be free from emotional, psychological, and physical abuse;
(P) The right to participate in appropriate programs of education, training, social development, and habilitation and in programs of reasonable recreation;
(Q) The right to participate in decisions that affect their lives;
(R) The right to select a parent or advocate to act on their behalf;
(S) The right to manage their personal financial affairs, based on individual ability to do so;
(T) The right to confidential treatment of all information in their personal and medical records;
(U) The right to voice grievances and recommend changes in policies and services without restraint, interference, coercion, discrimination, or reprisal;
(V) The right to be free from unnecessary chemical or physical restraints;
(W) The right to participate in the political process;
(X) The right to refuse to participate in medical, psychological, or other research or experiments.

Reporting Violations of Rights

Any person with MR/DD who lives at Anne Grady Services and believes that his/her rights, outlined above, have been violated, or any person acting in the best interest of the person living at Anne Grady Center, may bring the violation to the attention of social services at the Anne Gray Center. Attempts will be made to resolve concerns, however, if the concern continues to be unresolved the following agencies may be contacted.

Lucas County Board of MR/DD
2001 Collingwood Blvd.
Toledo, Ohio 43620
(419) 248-3585

Ohio Department of MR/DD
30 East Broad Street, Suite 1280
Columbus, Ohio 43215
(614) 466-5214
(800) 231-5872

Ohio Legal Rights Service
8 East Long Street, 5th Floor
Columbus, Ohio 43125
(614) 466-7264
(800) 282-9181

Anne Grady Services
Jack Mixon Natatorium
General Participant Release Form

I. General Information

1. Name: ____________________________ 2. Age: ___________________

2. Address: ____
Street City State Zip

3. Telephone #: ______________________

II. In accordance with pool policy, Anne Grady Services is informing you of the following rules and regulations:

1. I am aware that pregnant women, elderly persons, and persons suffering from heat related illnesses, heart disease, diabetes, or high or low blood pressure should not enter the pool/spa without prior medical consultation and permission from their doctor.
2. I will not use the pool/spa while under the influence of alcohol, tranquilizers, or other drugs that cause drowsiness or that raise or lower blood pressure.
3. I will not use spa/pool at water temperatures greater than 104 degrees F.
4. I will not use the spa/pool while alone.
5. I will observe reasonable time limits (10 to 15 minutes) when in the spa, then leave the water and cool down before returning for another brief stay.
6. I am aware that prolonged exposure to extreme heat may result in nausea, dizziness or fainting.
7. I am aware that a shower is required prior to using the pool/spa and recommended before getting in, and after getting out reducing the chances of skin irritation.

III. Participant Release:

I understand and agree to the above rules and regulations. . I am aware that there are risks, foreseeable and unpredictable, associated with any swimming program and agree that my participation is at my own risk. I hereby understand The Anne Grady Corporation, nor any cosponsoring organization or facility, nor their respective chapters, officers, directors, employees, agents, members, or volunteers, shall not assume or have any responsibility or liability for expenses or medical treatment or for compensation for any injury I may suffer during or resulting from my participation in this program. I do hereby, for myself, my heirs, executors and administrators, waive, release, and forever discharge any and all rights and claims for damages that I may have or that may hereafter accrue to me arising out of or in any way connected with my participation in this or any future programs. I also represent and warrant that I have been advised to seek consultation from my doctor about whether I can safely participate in this program and whether there are precautions or limitations to my participation.

Signature: _______________________________ Date:_________________________

Guardian: _______________________________ Date: _________________________

Emergency Contact: __________________________ Phone: __________

ANNE GRADY SERVICES RESPITE DEPARTMENT
STANDING ORDERS – ADULT RESPITE (Pg 1 of 2)

NAME: ______________________________

The following orders must be approved by the individual's Primary Care Physician or Waterville Family Physicians. The orders may be instituted by the wing nurse in consultation with the supervisory nurse or by the supervisory nurse after careful assessment of the person staying here. When used, they must be brought forward to the active physician's orders and recorded for 72 hours. Orders contraindicated should have a line drawn through them. All orders are PRN. All oral medications should be given only per g-tube if NPO and receives only enteral feedings.

SYMPTOMS:

1) **Constipation:**
- Check for impaction, PRN
- 3rd day: increase fluids, offer prune juice
- 4th day: Dulcolax suppository; Fleets or SS enema
- Milk of Magnesia 30cc PRN

2) **Diarrhea:** (3 or more loose/liquid movements QD)
- Immodium, 20cc STAT (4mg), 10cc (2mg) after each diarrhea stool thereafter; maximum 8 in 24 hours,
  then call M.D.

3) **Head Injuries:**
- Cranial assessments every 15 minutes x 4, then q1 hr. x 4, then q 4 hrs. until 24 hours from beginning of incident.

4) **Minor Skin Compromise:**
- Cuts, abrasions, contusions - cleanse with Betadine or hydrogen peroxide, apply Neosporin, band-aid/dry dressing.
- Diaper rash, irritation, dryness - Vaseline, A&D, Desitin.

5) **Epigastric Upset:**
- Maalox 30cc q4 hrs. PRN

6) **Dyspnea:**
- O2 given 2 liters/minute per nasal cannula or mask, PRN, maximum 45 minutes per application.
- Alupent aerosol .2cc with 3cc normal saline q 4 hrs. STAT if wheezing present **or** Proventil aerosol unit dose.
- Consult with supervisory nurse and notify M.D. if it continues to worsen or persists greater than 10 minutes, or if more than two aerosol treatments needed in 24 hours.

7) **Respiratory Congestion:**
- Suction orally
- Robitussin DM 10cc q4 hrs. PRN

8) **Nasal Congestion:**
- Sudafed PE 1 tab P.O. Q 4hrs. Do not take more than 6 doses in 24 hrs.
- Sudafed 30mg tab(for G-tubes dissolve in water) – 2 tabs P.O. Q4hrs. Max 240mg QD

* Contraindicated for individuals with diagnosis of Hypertension or Atrial Fib

9) **Cough:**
- Generic Robitussin DM 10cc q 4 hrs. PRN

STANDING ORDERS – ADULT RESPITE (Pg 2 of 2)

10) **Pain:**
- General – Tylenol 650mg. 1 q 4 hrs. PRN or Tylenol liquid 160mg/5ml give 20cc q 4 hrs. or 650mg. Supp.
- Joint/soft tissue – Motrin IB 400mg q 4 hrs. PRN, Motrin Suspension 400mgs q 4 hrs. PRN.

11) **Temperature Above 101° Rectally or 3° or more Above the Person's Normal:**
- Tylenol 650mg q 4 hrs. PRN or Tylenol liquid 160mg/5ml give 20cc q 4 hrs. or 650mg. Supp.
- Bed rest
- Begin temperature graph after 24 hrs.
- Motrin Suspension 400mgs q 4 hrs. PRN, Motrin IB 400mg. q 4 hrs. PRN

12) **Nausea/Vomiting:**
- Phenergan 25mg IM or suppository q 6 hrs.
- Bed rest
- Notify M.D. if no improvement within three consecutive doses.

13) **Urinary Retention:**
- Assessment 18-24 hrs. if no void.
- Straight cath PRN using #12-#18 Fr catheter, clamp for 5 minutes if output exceeds 1000cc.
- Check with nursing supervisor regarding contacting M.D.
- May straight cath, PRN for UA/C&S specimens.

14) **Itching/Scratching:**
- Benadryl 25mg/ 12.5mg/5ml q 6 hrs. PRN – not to be given without prior approval of supervisor.
- Hydrocortisone cream 1% top. Q 6 hrs. until healed.

15) **Bee Stings/Insect Bites:**
- Apply meat tenderizer poultice immediately to sting for two (2) hrs. Then apply Caladryl lotion PRN.
- Benadryl 25mg/ 12.5mg/5ml q 6 hrs. PRN itching or swelling. Cold compress to site, PRN for 30 minutes.
- For allergic reactions including dyspnea, facial or severe site swelling, give .3cc Epinephrine sub-Q STAT (use TB syringe) and notify M.D. STAT.

16) **Epistaxis:**
- Squeeze nose, tilt head forward. If persists, 1gtt of Tyzine each nare. Apply cold compress to the nose; repeat Tyzine each nare PRN.

Physician Signature: ___________________________________ Date: ________________________

ANNE GRADY SERVICES RESPITE DEPARTMENT
PEDIATRIC STANDING ORDERS (Pg 1 of 2)

NAME ____ DATE ____________________

These orders need to be signed by the child's Primary Care Physician, or Waterville Family Physicians. The orders may be may be initiated be the wing nurse in consultation with the supervisory nurse or by the supervisory nurse after careful assessment of the child staying here. When used, they must be brought forward to the active physician's orders and recorded for 72 hours. Orders contraindicated should have a line drawn through them. All orders are PRN. All oral medications should be given only per G-tube if NPO and receives only enteral feedings.

FOR FEVER OR DISCOMFORT:

TYLENOL 80MG/0.8 ML DROPS
6-11 lbs …….½ dppr/0.4 ml every 4 hours
12-17 lbs …..1 dppr/0.8 ml every 4 hours
18-23 lbs….. 1 ½ dppr/1.2 ml every 4 hours
24-35 lbs ….…..2 dppr/1.6 ml every 4 hours

TYLENOL 160 MG/5 ML ELIXIR
6-11 lbs….. … ¼ tsp. every 4 hours
12-17 lbs. ….. ½ tsp. every 4 hours
18-23 lbs… … ¾ tsp. every 4 hours
24-35 lbs………1 tsp. every 4 hours
36-47 lbs……1 ½ tsp. every 4 hours
48-59 lbs……… 2 tsp. every 4 hours
60-71 lbs…..…2 ½ tsp. every 4 hours
72-95 lbs ….……3 tsp. every 4 hours
96 lbs & over…. 4 tsp. every 4 hours

TYLENOL 80 MG CHEWABLE TABS
24-35 lbs ……2 tabs every 4 hours
36-47 lbs ……3 tabs every 4 hours
48-59 lbs …....4 tabs every 4 hours
60-71 lbs …..5 tabs every 4 hours
72-95 lbs…….6 tabs every 4 hours

TYLENOL 325 MG TABLETS
48-95 lbs ………… 1 tab every 4 hours
96 lbs & over …… 2 tabs every 4 hours

IBUPROFEN INFANT DROPS 50 MG/1.25 ML
12-17 lbs…………………1.25 ml every 6-8 hours
18-23 lbs………………..1.875 ml every 6-8 hours

IBUPROFEN ORAL SUSPENSION 100 MG/5 ML
12-17 lbs… ……………… ½ tsp. every 6-8 hours
18-23 lbs….. …………….. ¾ tsp. every 6-8 hours
24-35 lbs …………………. 1 tsp. every 6-8 hours
36-47 lbs.………………. 1 ½ tsp. every 6-8 hours
48-59 lbs ………………… 2 tsp. every 6-8 hours
60-71 lbs……………….. 2 ½ tsp. every 6-8 hours
72 -95 lbs……….. ………. 3 tsp. every 6-8 hours

IBUPROFEN JR STRENGTH 100 MG TABLETS
48-71 lbs……… …………2 tabs every 6-8 hours
72-95 lbs…………………..3 tabs every 6-8 hours

IBUPROFEN 200 MG TABLETS
48-71 lbs…… …………… 1 tab every 6-8 hours
72 lbs & over……… …… 2 tabs every 6-8 hours

FOR BEGINNING SIGNS OF NASAL CONGESTION:

SUDAFED LIQUID 30 MG/5 ML
<2 years ………………………… 4 mg/kg/day in divided doses every 6 hours (1 kg = 2.2 lbs)
2-6 years …………………………………………… ½ tsp. every 4-6 hours
6-11 years …………………………………………. 1 tsp. every 4-6 hours
12 years and older …………………………………. 2 tsp. every 4-6 hours

FOR COUGHS:

ROBITUSSIN DM LIQUID 100 MG/5 ML
<2 years ……………………….. 1-2mg/kg/day in divided doses every 6-8 hours (1kg = 2.2 lbs)
2-6 years …………………………………………… ½ tsp. every 4 hours
6-11 years …………………………………………. 1 tsp. every 4 hours
12 years and older ………………………………… 2 tsp. every 4 hours

PEDIATRIC STANDING ORDERS (Pg 2 of 2)

FOR CONSTIPATION:

GLYCERIN SUPPOSITORIES (After 3 days without BM)
1-5 years …………………………………………… 1 suppository
6 years and older ……………………………………. 2 suppositories

DULCOLAX SUPPOSITORIES (After 4 days without BM)
1-2 years …………………………………………….. ½ suppository
2 years and older …………………………………….. 1 suppository

FLEETS ENEMA
1-12 years ……………………………………………. 1 pediatric enema
12 years and older ……………………………………. 1 adult enema

FOR DIARRHEA:

KAOPECTATE LIQUID
Under 1 year ………………………………………… 1 tsp. three times a day
1-6 years ……………………………………………… 2 tsp four times a day

IMMODIUM ORAL SOLUTION 1 MG/5 ML
6-8 years (48-59 lbs) ………………………………… 2 tsp. after 1st loose stool
1 tsp. after each loose stool
thereafter (MAX/day – 4 tsp)
9-11 years (60-98 lbs) ……………………………….. 2 tsp. after 1st loose stool
1 tsp. after each loose stool
thereafter (MAX/day – 6 tsp)
12 years and older ……………………………………. 4 tsp. after 1st loose stool
2 tsp. after each loose stool
thereafter (MAX/day – 8 tsp)

IMMODIUM 2MG TABLET
6-11 years …………………………………………… 1 tab
12 years and older …………………………………... 2 tabs

FOR MINOR ABRASIONS:

1. Cleanse with Hydrogen Peroxide 5%
2. Apply triple antibiotic ointment twice a day
3. Notify the physician if necessary

FOR SKIN IRRITATION:

Apply A & D ointment to affected area twice a day

FOR BUG BITES/AREAS CAUSING ITCHING:

Apply Caladryl or Cortaid lotion topically to affected area 3 times a day

FOR NOSEBLEED:

Squeeze nose, tilt head forward. If persists, apply cold compress to nose.

Physician Signature X ____ **Date** ____________________

Guardian Signature X ____ **Date** ____________________