Stock Medication Order Form
Susquehanna Valley Central School District

A. To be completed by Parent/Guardian

I request that my child _____ DOB_____ Grade___
Receive that medications indicated below form school stock supply.

Signature (parent/Guardian) _____

Telephone _____ Date_____

B. Medications

Please check medications to be given from school stock and indicate dosage

- □ Ibuprophen /Advil 200mg/tab ____ tablet(s) every 6 hours as needed for pain /discomfort
- □ Ibuprophen/Advil suspension 100mg/5 ml_____ mg every 6 hours as needed
- □ Acetaminophen/Tylenol 325 mg/tab ____tablet(s) every 4 hours as needed for pain/discomfort
- □ Acetaminophen/Tylenol suspension 160 mg/5 ml____ mg every 4 hours as needed
- □ Diphenhydramine/Benadryl 25mg/tab____ tablet(s) every 4 hours for allergy/mild antihistamine reaction every 4-6 hours as needed.
- □ Diphenhydramine/Benadryl 12.4mgl ____mg every 4 hours for allergy/mild antihistamine reaction as needed
- □ Antibiotic ointment for cuts /superficial skin injuries as needed
- □ Cough drops as per package instruction as needed for sore throat
- □ Caladryl/Calamine lotion as needed for itching/insect bites
- □ Sun Screen apply as per package directions

Special Instructions_____
_____

C. To be completed by physician

Physician Name (print):_____
Signature: _____

Address: _____ Phone: _____

License # _____ NPI # _____ Title_____