

Stock Medication Order Form

Susquehanna Valley Central School District

A. To be completed by Parent/Guardian

I request that my child _____ DOB _____ Grade _____
Receive the medications indicated below from the school stock supply.

Signature (parent/Guardian) _____

Telephone _____ Date _____

B. Medications

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

- Ibuprofen/Advil 200mg/tab _____ tablet(s) every 6 hours as needed for pain / discomfort
- Ibuprofen/Advil suspension 100 mg /5 ml _____ mg every 6 hours as needed
- Acetaminophen/Tylenol 325mg/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 12.5mg/5ml _____ 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 instructions as needed for sore throat
- Caladryl/Calamine lotion as needed for itching/insect bites
- Sunscreen apply as per package directions

Special Instructions _____

C. To be completed by physician

Physician Name (print): _____

Signature: _____

Address: _____ Phone: _____

License # _____ NPI # _____ Title _____