

VIROQUA SCHOOL DISTRICT
STANDING ORDER FOR STOCK MEDICATION FORM

Scenic Bluffs School Health Services Standing Orders

No Child shall receive a medication or medication product without proper consent. Over-the-counter medications require parent authorization and can only be administered per manufacturer dosing instructions once parent approval is obtained.

Student Name:	Date of Birth:	School:	Grade:
---------------	----------------	---------	--------

Note: **For Medication brought from home, please fill out the "Prescription and Over-the-Counter Medication Form"**
(All prescription medication or medication to be given other than the package directions must be accompanied by a Medication Form signed by the practitioner and guardian.)

SCHOOL STOCK MEDICATIONS: I authorize the school to administer the following over-the-counter medications (brand or generic) based off package age/weight dosing guidelines if needed.
This order is in effect for this school year only. Select all that apply:

ORAL	TOPICAL
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> Bug Spray
<input type="checkbox"/> Cough Drop	<input type="checkbox"/> Chapstick/Lip Balm
<input type="checkbox"/> Diphenhydramine/Benadryl (Age 6+)	<input type="checkbox"/> Contact Solution
<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Diphenhydramine/Benadryl
<input type="checkbox"/> Tums/Antacids (Age 12+)	<input type="checkbox"/> Eye Drops
	<input type="checkbox"/> Hydrocortisone Cream
	<input type="checkbox"/> Lotion
	<input type="checkbox"/> Pain Relieving Spray
	<input type="checkbox"/> Sunscreen
	<input type="checkbox"/> Triple Antibiotic Ointment
<input type="checkbox"/> NO PERMISSION GIVEN	<input type="checkbox"/> Vaseline

Comments _____

I release the school district from any liability claims as a result of the administration of this medication or procedure as directed.

_____ Date	_____ Parent/Guardian Signature	_____ Phone #
---------------	------------------------------------	------------------