

**Complete This Portion for All Over the counter and Prescription Medications
That Staff will administer
PARENT ORDER FOR MEDICATION**

CHILD'S NAME _____ DATE OF BIRTH _____

NAME OF MEDICATION _____ DOSE (mg.) _____ TIME TO BE GIVEN? _____

REASON/SYMPTOMS TO MEDICATE: _____

DATE START _____ DATE STOP _____

CHILD'S PHYSICIAN _____ PHONE _____

I give my permission to the designated school personnel to give the above medication to my child according to the directions above. I agree to hold the Oregon School District and the persons designated to administer the above medication harmless in any events from the administration of this medication. I agree to notify the school, in writing, of any change in the above orders. I further agree to keep the supply of the medication replenished as needed, as I understand only a month's supply can be stored at the school.

DATE _____ SIGNATURE _____

HOME PHONE _____ WORK PHONE _____

.....
This portion to be completed by Physician for Prescription Medications only.
PHYSICIANS ORDER FOR MEDICATION

CHILD'S NAME _____ SCHOOL _____

DIAGNOSIS _____

MEDICATION _____

INCLUDE DOSE AND _____ FREQUENCY _____ TIME OF DAY(AT SCHOOL) _____

START DATE _____ STOP DATE _____ OR UNTIL THE LAST DAY OF SCHOOL _____

POSSIBLE SIDE EFFECTS _____

If as needed (PRN), state conditions under which medication should be given i.e., epinephrine for bee sting. _____

Your signature on this document attests to your willingness and intent to direct, supervise, decide, inspect, and oversee the administration of the medication by non-medically trained designees, and that you will accept direct communications from them regarding the administration of the medication. We urge that all instructions be stated in language of the lay person.

DATE _____ PHYSICIAN'S NAME _____

PHONE NUMBER _____ PHYSICIAN'S SIGNATURE _____

THIS ORDER MAY BE FAXED TO THE STUDENT'S SCHOOL: