Complete This Portion for <u>All Over the counter</u> and <u>Prescription Medications</u>

PARENT ORDER FOR MEDICATION

CHILD'S NAME____ DATE OF BIRTH________________

NAME OF MEDICATION________________________ DOSE (mg.)________ TIME TO BE GIVEN?__________

REASON/SYMPTOMS TO MEDICATE:____

IF TO BE GIVEN AS NEEDED, PLEASE COMPLETE: EVERY ________ HOURS AS NEEDED.

DATE START________________ DATE STOP______________ OR UNTIL THE LAST DAY OF SCHOOL_____

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 <u>Prescription Medications</u> only.

PHYSICIANS ORDER FOR MEDICATION

CHILD'S NAME____ SCHOOL______________________

DIAGNOSIS____

MEDICATION ____

INCLUDE <u>DOSE</u> 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__________________________

<u>THIS ORDER MAY BE FAXED TO THE STUDENT'S SCHOOL:</u>