

OREGON SCHOOL DISTRICT STAFF ADMINISTRATION OF MEDICATION FORM

PARENT ORDER FOR MEDICATION

Over the Counter Medication

Child's Name	Date of Birth	
Name of Medication	Dose (mg)	How often?
Date start	Date stop	
Reason for Medication		
Child's Physician	Physician Phone	

I give my permission to the designated school personnel to give the above medication to my child according to the directions listed 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 high school.

Signature	Date
Home Phone	Work Phone

Prescription Medications

This portion to be completed by the physician for administration of prescription medication

Child's Name	School
Diagnosis	
Medication(s)	
Dosage(s)	Frequency of Dose(s)
Start Date	Stop Date
Possible Side Effects	
If medication is on an "as needed" (PRN) basis, list the conditions under which the medication should be administered (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.

Physician's Name	Date
Physician's Signature	Phone Number

This order may be faxed to Oregon High School 608.835.7894