Actively Building Competency, Character, Culture & Community
OREGON SCHOOL DISTRICT

OVER-THE-COUNTER & STOCK MEDICATION CONSENT FORM & WAIVER OF LIABILITY

THIS FORM MUST COMPLETED AND SIGNED BY A PARENT/GUARDIAN BEFORE MEDICATION CAN BE ADMINISTERED AT SCHOOL.

STUDENT'S NAME: _____SCHOOL:_____

INDICATION/DIAGNOSIS:_____

_____

MEDICATION NAME***	DOSE	FREQUENCY	START DATE	END DATE (OR UNTIL LAST DAY OF SCHOOL)

STUDENT'S PRIMARY MEDICAL CARE PROVIDER_____

PHONE_____ EMAIL: _____

I give my permission to the designated school personnel to give the above medication to my student according to the directions above. I agree to release from all liability and hold the Oregon School District and its employees harmless in any and all 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 over-the-counter medication replenished as needed; I understand only a month's supply can be stored at the school.

***OSD may provide the following stock medications: acetaminophen, ibuprofen, and diphenhydramine.

DATE:_____PRINT NAME:_____

SIGNATURE:_____

PREFERRED PHONE:_____

PREFERRED EMAIL:_____