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

PRESCRIPTION MEDICATION CONSENT FORM & RELEASE OF LIABILITY

THIS SECTION MUST COMPLETED AND SIGNED BY A PARENT/GUARDIAN:

STUDENT'S NAME: _____DATE OF BIRTH:_____SCHOOL:_____

I give my permission to the Oregon School District staff to give the medication listed below to my STUDENT according to the directions provided. I agree to release from 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 orders. I further agree to keep the supply of the medication replenished as needed. I understand only a month's supply can be stored at the school. I also give permission for the school nurse to communicate with the prescribing provider regarding this prescription.

DATE:_____PRINT NAME:_____

SIGNATURE:_____ PREFERRED PHONE:_____

PRESCRIBING PROVIDER'S NAME:_____PHONE:_____

MEDICATION:_____DOSE:_____TIME:_____
MEDICATION:_____DOSE:_____TIME:_____
MEDICATION:_____DOSE:_____TIME:_____
MEDICATION:_____DOSE:_____TIME:_____

THIS SECTION MUST COMPLETED AND SIGNED BY THE PRESCRIBING PROVIDER:

INDICATION/DIAGNOSIS:_____

If as needed (PRN), state conditions under which medication should be given: _____

MEDICATION NAME	ROUTE	DOSE	FREQUENCY	DURATION

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:_____PRESCRIBING PROVIDER'S NAME:_____

PRESCRIBING PROVIDER'S SIGNATURE:_____PHONE: _____

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