Oregon Community Unit School District #220

206 South Tenth Street, Oregon, Illinois 61061

Oregon High School Phone 815-5300 Ext 1122 815-732-5397	David L.Rahn JH School Phone 815-734-5300 Ext 3106 Fax 815-732-5397 Jhernandez@ocusd.net	Oregon Elementary School Phone 815-732-5300 Ext 2222 Fax 815-732-5396 shoover@ocusd.net

Consent for Administration of Prescription Medication

Oregon C.U.S.D. #220 School Policy states that medications may be given to students *only upon written prescription of a physician and the written request of a parent/guardian*. It also states that students may participate in self administration of medications. All information is kept confidential, and will become a permanent part of your child's health record.

STUDENT NAME: _____BIRTHDATE: _____

SCHOOL: _____ GRADE: _____ TEACHER: _____

PARENT REQUEST SECTION:

As the parent or legal guardian of the above named student, I hereby request that the school nurse or other authorized school personnel give the prescription or medication as designated below.

****Parent Signature**: _____ Phone: _____ Date: _____

TO SEND MEDICATION TO SCHOOL:

1. The prescription-labeled or original medication container must be sent.
2. On the medication container must be written the student's name, doctor's name, date, medication, dosage and the time to be given.
3. All medications will be kept in the school office **unless** we receive a doctor's order for your child to carry it with him. (Example: epi-pen)

PHYSICIAN REQUEST SECTION:

Medication Name: _____

Amount to be Given: _____

Time/Times to be Given: _____

Start Date: _____ Discontinue Date: _____ Re-Eval. Date: _____

Diagnosis Requiring Medication:

_____

Expected Side Effects, if any: _____

Dosage & Times Given at Home: _____

Other Medications Child Takes: _____

Approval for student to carry emergency medication (Inhaler/Epi-pen/insulin) YES NO (Recommend age 10 years and over only)

I hereby request that the school nurse or other authorized school personnel give the prescription designated above, as it is medically necessary for dose(s) to be given during school hours.

Physician's Name: _____ Physician's Signature: _____ Date: _____

Physician's Address: _____ Phone: _____ Fax: _____

School Nurse Signature_____Date_____