Orange County School of the Arts

Multiple Medication Protocol

Student Name:_____ Date of Birth:_____

This student has been prescribed multiple medications that may be taken during the school day. Please have the prescribing physician complete this form ***including the physician's office stamp.***

PHYSICIAN'S USE ONLY:

Order medications to be given in:

1._____ dose:_____
medication

Time:_____ if PRN: Amount of time between doses:_____

May be taken with _____
Amount of time between doses:_____

May **NOT** be taken with_____

2._____ dose: _____
medication

Time:_____ if PRN: Amount of time between doses:_____

May be taken with _____
Amount of time between doses:_____

May **NOT** be taken with_____

3._____ dose:_____
medication

Time:_____ if PRN: Amount of time between doses:_____

May be taken with _____
Amount of time between doses:_____

May **NOT** be taken with_____

Physician Signature:_____

Date:_____

Physician's Office Stamp

Parents / Guardian's Signature:_____

Date:_____