Release of Medical Information & Physician Order to Dispense Medication Date:_____ (expires 365 days from completion)

Warrior Name: _____ DOB: _____

For medications taken during non-program hours (at home): Please only complete: medication, purpose, and potential side effects.

For medications administered by staff of Opportunity Knocks, Inc. (hereinafter "Opportunity Knocks" or "OK") staff: Opportunity Knocks requires up to date medical records that will identify the name, purpose, and dose of given medication. For each medication the name and contact information for each physician must be provided. Opportunity Knocks reserves the right to contact each doctor to discuss the purpose and possible side effects for medication and you hereby consent to OK doing so by signing this document and giving it to OK. Opportunity Knocks administers medication under the following guidelines:

- A physician (MD), physician's assistant (PA), or nurse practitioner (NP) has signed and dated a Physician's Order sheet. A parent or guardian has signed and dated an Authorization for the Administration of Medication sheet.
- The medication is brought to Opportunity Knocks in its original container with a prescription label, or if it is an over the counter medication, the manufacturer's label.
- The prescription label contains the member's name, name of medication, dosage, instructions, start date, and expiration date that has not yet expired.
- Physician's Order is completed once and then renewed on an annual basis or as medication changes occur.
- Complete this form if medication is to be administered by OK staff - medications taken during non-program times and not involving OK staff do not require this form and do not require a physician's signature.
- OK will comply with applicable provisions of the Health Insurance Portability and Accountability Act (HIPPA).

Signature & Title of MD, PA, or NP:_____ Date: _____
**only required if medication is administered by OK staff*

I, the undersigned parent or guardian of the Warrior named above, consent to the aforegoing and agree to let Opportunity Knocks know of any changes in medication including changes in doses and/or medication.

Parent or Guardian: _____ *Warrior Signature:* _____

Printed Name: _____

Medication Name (OTC & Rx) _____ Dosage: _____ Time Given: _____

Purpose_____

Instructions: _____

Potential Side Effects: _____

_____

Prescribing Doctor Name (print): _____ Dr. Contact phone: _____

Medication Name (OTC & Rx) _____ Dosage: _____ Time Given: _____

Purpose_____

Instructions: _____

Potential Side Effects: _____

_____

Prescribing Doctor Name: _____ Dr. Contact phone: _____
**only required if medication is administered by OK staff*

Medication Name (OTC & Rx) _____ Dosage: _____ Time Given: _____

Purpose_____

Instructions: _____

Potential Side Effects: _____

_____

Prescribing Doctor Name: _____ Dr. Contact phone: _____

Medication Name (OTC & Rx) _____ Dosage: _____ Time Given: _____

Purpose_____

Instructions: _____

Potential Side Effects: _____

_____

Prescribing Doctor Name: _____ Dr. Contact phone: _____