Authorization for Medication Administration by School Personnel

To Principal of Le Monde French Immersion Public Charter School:

Student Name:_____ DOB:_____ Grade:_____

I am giving school personnel **permission** to administer medications to my child per the following (Complete all underlined sections):

Name of Medication: _____

Dose (prescribed amount, e.g. 5 mg., **not** 1 pill) _____

Check One: ___ Prescription; Requires physician direction (see below)
___ Non prescription

ALL MEDICATION MUST BE IN ITS NEWEST ORIGINAL CONTAINER WITH ACCURATE LABEL.

PRESCRIPTIONS MUST BE WRITTEN BY OREGON-LICENSED PHYSICIANS.

Other (Describe): _____

Tablets requiring cutting should be cut by the parent before being brought to school. Liquid medication requiring dosage spoons, available from your pharmacist, to be supplied by parent.

Route: **(circle one):** By: Mouth Ear Eye Nose Skin Inhalation

Time of day to be given at school (e.g. 11 a.m., **not** mid-day) _____

Duration: Start date_____ end date_____

Reason for Medication: _____

Special Instructions: _____

____ Please allow my child to self-administer this medication. Refer to district policy on self-medication). *Requires self- medication agreement form to be signed by parent, school administrator, and, if prescription, consent of physician. (See below)*

I understand: I am responsible **to provide this medication** and maintain the supply as needed; to **notify the school** in writing of any changes in the medication or prescriber; to **pick up** all unused medication by the last day of school (or it will be discarded). This authorization is **valid no longer than one year** from this date and applies only to the medication above; this **authorizes an information exchange,** as necessary, between the school nurse, appropriate school personnel, and/or my child's health provider.

Parent/Guardian

Signature:_____ Date:_____

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OREGON LICENSED PHYSICIAN DIRECTION

(Required in writing or on pharmacy label for all prescription medications per OAR 581-021-00371).

____ I have prescribed the above medication for the student whose name appears at the top of this form.

____ Instructions in the box are accurate. Please allow this student to carry and self-administer this medication. (Must be allowed by school district policy. Student must be developmentally and behaviorally able to self-administer.)

____ Special instructions including adverse reactions and action required:

_____

_____

Oregon-Licensed Physician's Name (please print/stamp)

_____ Oregon-Licensed Physician's Signature

_____ Address

_____ Phone #

_____ Effective Date