Authorization for Medication Administration by School Personnel

Student Name:_____DOB:_____Grade: ___

School Name: Le Monde French Immersion Charter School Teacher: _____

I am giving school personnel permission to administer the following medication to my child (Complete all sections):

Medication Name: Dose (amount; for example, 5 mg., **not** 1 pill) Method of administration **(circle one)**: By: ☐ Mouth ☐ Ear ☐ Eye ☐ Nose ☐ Skin ☐ Inhalation Time of day to be given at school: Duration: start date end date Reason for Medication:	Check One: ☐ Prescription - Requires physician direction (see below[1]) ☐ Nonprescription – must follow manufacturer's recommended dosing guidelines, otherwise requires prescription Special Instructions:

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* ALL MEDICATION MUST BE IN THE MOST RECENT ORIGINAL PHARMACY OR MANUFACTURER'S CONTAINER WITH AN ACCURATE LABEL, AND MUST NOT BE EXPIRED. TABLETS REQUIRING CUTTING ARE TO BE CUT BY THE PARENT OR PHARMACIST BEFORE BEING BROUGHT TO SCHOOL. LIQUID MEDICATION REQUIRES A DOSAGE SPOON/CUP (AVAILABLE AT YOUR PHARMACY). MEDICATION THAT MUST BE CRUSHED REQUIRES A PILL CRUSHER (AVAILABLE AT YOUR PHARMACY) AND A SUBSTANCE TO MIX POWDER INTO (TO BE PROVIDED BY PARENT).

PRESCRIPTIONS MUST BE WRITTEN BY AN OREGON-APPROVED PRESCRIBER, AND HAVE A PHARMACY LABEL THAT INCLUDES[1]:

- Student name
- Medication name
- Dose
- Time/frequency of administration

_____ _____

Oregon-licensed[1] healthcare prescriber's name Phone number

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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 destroyed). This authorization is valid only until the end of this school year and applies only to the medication above. Parent signature below **authorizes an exchange of information**, as necessary, between the school nurse, necessary school personnel, or the student's healthcare provider.

Parent/Guardian/Student Signature:_____Date: _____

[1] **Required in writing or on pharmacy label for all prescription medications per OAR 581-021-0037**