Authorization for Medication Administration by School Personnel

Le Monde French Immersion Public Charter School

Le Monde staff will only administer medications, whether over the counter or prescribed, with Oregon-approved prescriber directions. Le Monde will not administer any medications without prescriber directions.

Prescription medications must be prescribed by an Oregon-approved prescriber and have a pharmacy label that includes (per OAR 581-021-0037):

- Student's first and last name
- Medication Name
- Dose
- Time/frequency of administration

Over the counter (non-prescription) medications must be accompanied by Oregon-approved prescriber directions for administration, **and must be delivered to the school in its original packaging.**

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 in which to mix the powder to be provided by the parent or guardian.

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

Student Name: _____ Date of Birth: _____

Grade and Teacher: _____

Medication Name: _____

Dose (amount; for example, 5 mg, NOT 1 pill): _____

Method of Administration (check one):

By: ☐Mouth ☐Ear ☐Eye ☐Nose ☐Skin ☐Inhalation

Time of Day to be given at school: _____

Duration: Start date: _____

End date: _____

Special Instructions: _____

_____

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/Guardian/Student Signature: _____ Date: _____