Health Services · Student Services Department
Nurse Helpline: 503.399.3376

SELF-MEDICATION AGREEMENT

Students who are developmentally and/or behaviorally able, will be allowed to self-administer prescription and non-prescription medication, subject to the following:

1. A permission form must be submitted for self-administration of all prescription and non-prescription medication.
   a. Self-administration of prescription medication requires permission from parent, school administrator and prescriber or School Health Registered Nurse. Signature of prescriber on this self-medication agreement indicates consent/need for student to self-carry at school.
   b. Self-administration of FDA approved non-prescription medication requires permission and signatures from parent and school administrator. *(Office staff: notify the building's School Health Registered Nurse)*
   c. Self-administration of non-FDA approved medication must also include a written order from a prescriber.
2. All prescription and non-prescription medication must be kept in its appropriately labeled, original container, as follows:
   a. Prescription labels must specify the name of the student, name of the medication, dosage, route, and frequency or time of administration and any other special instructions.
   b. Non-prescription medication must have the student's name affixed to the original container.
3. The student may have in their possession only the medication listed below. Sharing and/or borrowing of medication with another student is strictly prohibited.
4. Permission to self-medicate may be revoked if the student violates school district policy governing administration of non-injectable medication and/or these regulations. Additionally, the student may be subject to discipline, up to and including expulsion, as appropriate if the self-medication policy is violated.
5. Parent/guardian is responsible for ensuring the student's prescription is up-to-date, the medication is not expired, and a copy of the prescription and/or physician treatment form is provided to the school every year.

STUDENT NAME:	**STUDENT ID#:**	**SCHOOL/PROGRAM:**

NAME OF MEDICATION(S):

Additional Instructions:

☐ I agree to comply with the above criteria.

X

STUDENT SIGNATURE **DATE**

☐ I have read and agree to the above criteria and give permission for my child to carry and self-administer the above medication(s) independently. I understand that this agreement is in effect until my child graduates, or I revoke my permission in writing to my child's school

X

PARENT/GUARDIAN SIGNATURE **DATE**

☐ **This student may carry and self-administer this medication as prescribed.**
☐ **This student may self-administer this medication as prescribed, but the medication will be kept in the office.**
☐ This student has been instructed in the correct and responsible use of this prescribed medication.

☐ *Please see treatment plan attached.*

X

SIGNATURE OF PRESCRIBER/SCHOOL HEALTH REGISTERED NURSE **DATE** **PHONE**

X

SIGNATURE OF SCHOOL ADMINISTRATOR/DESIGNEE **DATE**

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☐ This student has been instructed in the correct and responsible use of this prescribed medication.

☐ *Please see treatment plan attached.*

X

SIGNATURE OF PRESCRIBER/SCHOOL HEALTH REGISTERED NURSE **DATE** **PHONE**

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☐ *Please see treatment plan attached.*

X

SIGNATURE OF PRESCRIBER/SCHOOL HEALTH REGISTERED NURSE **DATE** **PHONE**

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☐ *Please see treatment plan attached.*

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SIGNATURE OF PRESCRIBER/SCHOOL HEALTH REGISTERED NURSE **DATE** **PHONE**

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☐ *Please see treatment plan attached.*

X

SIGNATURE OF PRESCRIBER/SCHOOL HEALTH REGISTERED NURSE **DATE** **PHONE**

X

SIGNATURE OF SCHOOL ADMINISTRATOR/DESIGNEE **DATE**