

DISTRICT NAME

## SELF-MEDICATION AGREEMENT

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

1. A permission form must be submitted for all self-medication of prescription and nonprescription medication.
    - Self-medication of prescription medication requires permission from parent, school administrator and physician. Physician consent is to be included on the prescription label or on the medication consent form.
    - Self administration of non-prescription medication requires permission from parent and school administrator.
  2. All prescription and nonprescription medication must be kept in its appropriately labeled, original container as follows:
    - 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.
  3. Physician's consent for self-administration must either be on the prescription label or on this form.
  4. Sharing and/or borrowing of medication with another student is strictly prohibited.
  5. 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.
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Student Name: \_\_\_\_\_

I have read and agree to the above criteria and give permission for my child to self-administer:

Name of medication: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(My signature authorizes an exchange of information as necessary between the school and my child's health provider for the purpose of information relating to this medication.)*

I agree to comply with the above criteria:

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please allow this student to self-administer this medication. (Student must be developmentally and behaviorally able to self-administer.)

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Required for prescription medications)

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\_\_\_\_ 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.

School Administrator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_