ESTACADA SCHOOL DISTRICT
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Authorization for SELF-Medication

Student Name:______________________________ **Grade:**_______ **DOB:**______________

School:____ School Year: ______________

☐ **I am giving the school permission to allow my child to carry their personal medication (listed below), monitor their own symptoms, and self-administer their own doses.**

*If this medication is an Epi-pen, or other epinephrine auto injector, for the treatment of anaphylaxis, it is strongly recommended that you provided the school with a back-up injector.

Medication name:

Dose*: (example: "5 mg". Not "1 pill")

**Tablets requiring cutting need to be cut by the parent before being brought to school. Dosage spoons for liquid medications, or other measuring devices are to be supplied by the parent.*

Method of Administration: (circle one or explain)
Mouth Ear Eye Nose Inhalation
Intramuscular Rectal Skin

Time of day/ Frequency of Administration:
(example: "11am", not "mid-day")
As needed or specific time:____________________________

Check One:

☐ **Prescription #**____________________________
ALL MEDICATION MUST BE IN ITS NEWEST, ORIGINAL CONTAINER WITH PHARMACY LABEL ATTACHED TO THE CONTAINER.
PRESCRIPTIONS MUST BE WRITTEN BY OREGON-LICENSED PHYSICIANS ONLY.

☐ **Non-prescription: STUDENTS NAME MUST BE WRITTEN CLEARLY ON THE CONTAINER.**

☐ **Special instructions:**

Duration: Start date__________End date___________ or ☐ last school day of current school year.

Reason for medication: (circle one or explain)
ADD/ADHD Allergic reaction Asthma Diabetes Infection Pain Seizures Other:

***This form must be filled our completely and signed by all parties. All prescription medications must have prescription label attached to container. All non-prescription medication will have students name affixed to the container. Sharing or borrowing another person's medication is strictly prohibited. This privilege can be revoked at any time if the policy is violated. This contract may be voided at any time, by any one of the signing parties or by a medication or condition change. This agreement is for the current school year only.**

PARENT: I have read and agree to the above guidelines. I understand that my child will be responsible to monitor their symptoms, assess when/if medication is necessary, and self-administer their own doses. The school will not keep a record documenting doses taken. In granting this permission for my child to self-medicate, I hereby absolve the Estacada School District and all its employees from any liability or legal responsibility for any condition that might arise from the administration or lack of administration of such medication.
Signature: ____Date:__________________

STUDENT: I have read and agree to the above guidelines. I understand my condition and when and how to take my medication. I will never share my medication with anyone else. I will immediately go to my teacher or the office if I am having any severe breathing problems, serious side effects, or if the dose I take does not seem to be working. I hereby absolve the Estacada School District and all its employees from any liability or legal responsibility for any condition that might arise from the administration or lack of administration of such medication.
Signature: ____Date:__________________

PRINCIPAL: This student has demonstrated understanding of their condition, knowledge about the medication and appears capable of self-management.
Signature: ____Date:__________________