Jesuit High School
Self- Medication Agreement

TO BE COMPLETED BY PARENT/GUARDIAN
Student Name: DOB/Grade:

This self-agreement form must be submitted for all self-medication that may happen on the Jesuit High School Campus, field trips or school events. Students must be developmentally and behaviorally able to self medicate. In addition to this form, students will fill out the Authorization for Medication Administration form signed by a healthcare provider. To self carry the student has been instructed in the proper use and medication and fully understands how it is to be administered. The following criteria must be met by the student:

1. All medication must be kept in its labeled, unexpired, original container. If the medication is a prescription by a medical professional the label must specify; name of student, name of medication, dosage, route, frequency or time of administration and any other special instructions. Self-administration of non-prescription or non FDA approved medication must include a written order from a prescribing physician.
2. Sharing and/or borrowing medication with another student is strictly prohibited.
3. Permission to self medicate and self carry may be revoked if the student violates school policy governing administration of medication and/or these regulations. Additionally, the student may be subject to discipline, up to and including expulsion.
4. Students are responsible for checking in with the health office to keep them informed of any medication changes. All changes must be done in writing. It is strongly recommended that students have back up medicine stored in the health room.
5. Parents and/or guardians release Jesuit and the Archdiocese of Portland of any liability related to the prescription use of the medication(s) below.

Student and parent/guardian have read and agree to the above criteria and give permission to self administer and self carry the medication(s).

Name of Medication(s):_____

_____

Student Signature:_____Date:_____

Parent/Guardian Signature:_____Date:_____

School Health Nurse Signature:_____Date:_____