Central Point School District #6

300 Ash Street, Central Point, Oregon 97502
541-494-6200 www.district6.org

SELF-MEDICATION AGREEMENT

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

1) This Self-Medication Agreement form must be submitted for all self-medication.
- Self-administration of non-prescription medication requires this form and permission from a school administrator. Self-administration of non-FDA approved medication must also include a written order from a prescriber.
- Self-administration of prescription medication requires this form, and permission from a school administrator and either an RN practicing in the school setting or a prescriber. Prescriber consent can be included on the prescription label or on this self-medication agreement form.

2) All 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, frequency or time of administration and any other special instructions.
- Nonprescription medications must have the student's name affixed to the manufacturer's original container.

3) The student may have in their possession only the amount of medication needed for that school day, except for manufacturer's packaging that contains multiple dosage, the student may carry one package, such as, but not limited to, auto injectable epinephrine or bronchodilators/ inhalers.

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 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.

Student Name: _____

Name of Medication: _____

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

Parent Signature: _____ Date: _____

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.)

Prescriber or RN Signature: _____ Date: _____

School Administrator's Signature: _____ Date: _____