

**GREATER ALBANY PUBLIC SCHOOLS  
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 include a written order from a prescriber)
  - Self-administration of prescription medication requires this form, and permission from a school administrator and either a 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, and frequency or time of administration and any other special instructions.
- 3) 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 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 Legal Last Name	Legal First Name	Middle Name
-------------------------	------------------	-------------

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

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

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I agree to comply with the above criteria:

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(if not already signed)

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

Prescriber or RN Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Required for prescription or non-FDA approved over the counter medications)

---

\_\_\_\_ 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: \_\_\_\_\_