



School Health Services Multnomah Education Services District (MESD)

Student Self-Medication Agreement

Student Name: _____ Student ID Number: _____
Student DOB: _____ School Name: _____

Students who are developmentally and/or behaviorally able and are requesting to self-administer a prescription¹ and/or non-prescription medication will be allowed to self-carry and self-administer the medication (without the assistance of school staff) under district policy and are subject to the following:

1. This Student Self-Medication Agreement form must be signed and submitted.
2. All medication(s) must be kept in its/their original container and be appropriately labeled.
3. For prescription medications: prescription labels must specify the name of the student, name of the medication, dose route, frequency/time of administration and any other special instructions.
4. For nonprescription medications: the medication must have the student's name affixed to the original container.
5. The student only self-carries the amount of medication needed for that school day (multi-dose medications such as inhalers are allowed).
6. The student is aware that they are responsible for taking the medication as prescribed and/or directed without the assistance of school staff (the student may request assistance if needed).
7. The student will notify school staff if they suspect they are having side effects from the medication, an increase in symptoms or their symptoms were not relieved by the medication.
8. The student is aware that sharing and/or borrowing the medication(s) is strictly prohibited.
9. The permission to self-carry/self-medicate may be revoked if the student violates school district policy.
10. The parent/guardian is aware and understands that school staff will not be guiding, monitoring, or documenting the student's medication needs and activities.

Medication to be self-carried and self-administered:

Medication Name: _____	Medication Dose: _____
Medication Name: _____	Medication Dose: _____
Medication Name: _____	Medication Dose: _____

I have read and agreed to the above criteria:

_____ Parent/Guardian Name	_____ Parent/Guardian Signature	_____ Date
_____ Student Name	_____ Student Signature	_____ Date
_____ School Administrator Name	_____ School Administrator Signature	_____ Date
_____ School Nurse Name	_____ School Nurse Signature	_____ Date

¹ Per the American Academy of Pediatrics (AAP), students, "should generally not carry controlled substances or assume full responsibility for taking them at school. Medications like these should be secured in the school health office for the well-being of all students and staff. Please refer to district policy for controlled substances.