North Santiam
School District

Code: **JHCD/JHCDA-AR(2)**
Revised/Reviewed: 6/23/11; 4/16/15; 10/19/17
Orig. Code(s): JHCD/JHCDA-AR(2)

# Self-Medication Permission Form and Agreement

Student Name: _____ School Year: _____ Grade: _____
(PLEASE PRINT)

**ALL:** Student must be able to demonstrate the ability, developmentally and/or behaviorally, to self-administer prescription and nonprescription medication.

**K-8:** Self-medication of prescription and non-prescription medication is only allowed when a student must carry such medication on his/her person for immediate access.

**9-12:** Self-medication of prescription, excluding controlled substances and nonprescription medication may be allowed subject to the following:

- Self-medication form is required for all regularly scheduled prescription medication, which a student will take at school for more than 10 school days.
- A permission form must be submitted for self-medication of all "as needed" prescription medications, which a student carries with them at school. (This includes inhalers).
- No permission form is required for self-medication of nonprescription medications.

➢ Self-medication of controlled substances and narcotic analgesics are not allowed. These medications must be checked into the office.

➢ **This agreement is only in effect for current school year.**

| Student Initial | Parent Initial | |
|---|---|---|
| ____ | ____ | All prescription and non-prescription medication must be kept in its appropriately labeled, original container, as follows:<br>❖ Prescription labels must specify the name of the student, name of the medication, dosage, route, frequency or time of administration, expiration date, and any other special instructions including physician authorization for student to self-medicate. Inhalers must have a pharmacy label attached or be in a labeled pharmacy dispensed box.<br>❖ Nonprescription medication **must have the student's name** affixed to the **original container**. Student is limited to 25 pills or less in their possession. |
| ____ | ____ | Students needing to self-medicate must carry their medication with them for immediate access; i.e., personal bag/purse, backpack, pocket, etc. Medication should not be left on desks, countertops or other places where others would have access to their medication. Sharing and/or borrowing of medication with another student **are strictly prohibited**. Sharing and/or borrowing of medications with another person at school or school related activities is grounds of disciplinary action up to and including expulsion. |
| ____ | ____ | Students needing to self-medicate must carry their medication with them for immediate access; i.e., personal bag/purse, backpack, pocket, etc. Medication should not be left on desks, countertops or other places where others would have access to their medication. Sharing and/or borrowing of medication with another student are strictly prohibited. Sharing and/or borrowing of medications with another person at school or school related activities is grounds of disciplinary action up to and including expulsion. |
| ____ | ____ | For students who have been prescribed bronchodilators or epinephrine, school staff will request the parent/guardian to provide backup medication for emergency use by that student. Backup medication will be kept at the student's school in a location which the staff has immediate access in the event the student has an asthma and/or severe allergy emergency. |
| ____ | ____ | Permission to self-medicate may be revoked if the student violates school district policy governing administration of all medications and/or these regulations. Additionally, students may be subject to discipline, up to and including expulsion, as appropriate. |

**Medications indicated below must match name of medication on container.**

1. _____ 3. _____
2. _____ 4. _____

**I have read and agree to the above criteria.**

_____ _____
*Student Printed Name/Signature and Date* *Parent/Guardian Printed Name/Signature and Date*

**School Administrator Approval** – I have verified the student is developmentally and/or behaviorally able to self-administer.

_____
*Printed Name/Signature and Date*

**NSSD School Nurse Approval**
(Grades K-8)

_____
*Printed Name/Signature and Date*

**Physician Authorization-Prescription Medication ONLY**
□ Prescription Label □ Letter □ Fax

_____
*Printed Name/Signature of Verifier and Date*