Corvallis
SCHOOL DISTRICT

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 non-prescription 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.

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

Student Initial | **Parent Initial**

_____ _____ All prescription and non-prescription 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, expiration date, and any other special instructions including physician authorization for student to self-medicate.
- ❒ Non-prescription medication **must have the student's name** affixed to the **original container**.

_____ _____ The student may have in his/her possession only the amount of medication needed for that day. For manufacture's packaging that contains multiple dosages, the student may carry one package, such as but not limited to, bronchodilators/inhalers, insulin pens or pumps.

_____ _____ 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.**

_____ _____ For students who have been prescribed bronchodilators, epinephrine, and glucagon, 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 or hypoglycemic emergency.

_____ _____ Student will not dispose medication, containers, syringes and/or lancets at school. Disposal will be done at home as appropriate.

_____ _____ 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)

Corvallis 509J School Nurse Approval
(Grades K-8)

____
(Printed Name/Signature and Date)

Physician Authorization-Prescription Medication ONLY
❑Prescription Label ❑Letter ❑Fax

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Printed Name/Signature of Verifier and Date