## <u>SCIO SCHOOL DISTRICT</u>

# Self-Medication Permission Form and Agreement

**Student Name:** ______________________________________________________________

**DOB:**______________ **Grade:** _________________ **School Year**: ___________________________

### ALL MEDICATIONS MUST BE IN ITS UNEXPIRED, ORIGINAL CONTAINER WITH ACCURATE LABEL

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

**<u>K-8</u>:** 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 *(Epi-Pen, Inhaler)*

**<u>9-12</u>:** Self-medication of prescription medication, including all “as-needed” prescriptions, and the ability to carry it with the student at school, may be allowed when a permission form has been submitted.

No permission form is required for self-medication of non-prescription medications.

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

| Student Initials | Parent Initials | This agreement is only in effect for the current school year. |
|---|---|---|
| ______ | ______ | ● 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>○ Non-prescription medication must have the students name affixed to the original container. Students are 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, locker, 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 **<u>strictly prohibited.</u>** |
| ______ | ______ | ● 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. |

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Medications indicated below must match name of medication on container

1. ____________________________________________
2. ____________________________________________
3. ____________________________________________
4. ____________________________________________

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

**Student Signature** ______________________________ **Date** __________

**Parent/Guardian Signature** ______________________________ **Date** __________

*(This authorization applies only to the medication listed above and for the duration of treatment or current school year)*

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STAFF USE ONLY

☐ I have verified the student is developmentally and/or behaviorally able to self-administer

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*(Signature of School Administrator or District Nurse* Approval)*

**District Nurse Approval Required for Grades K-8*

**Physician Authorization-Prescription Medication ONLY**

☐ **Prescription Label** ☐ **Letter** ☐ Fax

______________________________________________

*(Signature of Verifier and Date)*