Sweet Home School District

PARENTAL REQUEST FOR

SELF ADMINISTRATION OF medication K-12

In compliance with ORS 326.051, OAR 581-021-0037 and Sweet Home School District Policy JHCD, provide for self-medication of *selected* prescription and nonprescription medications. Requests for designated students to self administer medication may be approved by the district when the following criteria are met:

1. All *prescription* medication must be in the appropriately labeled prescription container. The label must include: [a] the name of the student [b] name of the medication [c] name of the prescribing physician [d] route of administration [e] dosage [f] frequency of administration [g] special instructions, if any. This signed parental request form must accompany the medication.
2. *Non-prescription* medication must have the student's name permanently affixed to the original container.
3. Medication that is categorized as a sedative, controlled substance, stimulant, anti-convulsant, narcotic analgesic, or psychotropic must be locked up. These medications do not fall under the self-medication policy.
4. The student may have in their possession only the amount of medication needed for that school day.
5. Sharing and/or borrowing of medication with other students is strictly prohibited. Permission to self-medicate may be revoked if the student violates the Board Policy governing medication administration. Students may be subject to discipline, up to expulsion, as appropriate.
6. Medications required for use longer than ten school days may not come under self-medication provision.

Student Agreement Form

- I understand that permission to self-medicate is a privilege which may be revoked if the following conditions are not met:
- Students must demonstrate that they are behaviorally and developmentally able to self-medicate in a safe manner.

Student: ____

Name of Medication: ____________________________________ Prescription { }Nonprescription { }

Dosage: _________________________________ Route: ___________________________

Frequency of Administration: _____________________________at: ______________________ o'clock.

Date of Initial Dose: _______________Length of Time Expected To Be Needed: ___________________

Valid Expiration Date (must not be expired): ___________Special Instructions: ____________________

Parent Signature: ____Date: _____________

(My signature authorizes an exchange of information as necessary between the school and my child's health provider for the purpose of information relating to this medication.)

District RN and Administrator signature: _____________________________Date: _________________

__________________________________Date: ________________