Three Rivers Charter School
503-673-7850

Self-Medication Agreement

Student Name:	
Date of Birth:	
School:	
Grade:	
School Year:	

1. Medication Name:	
2. Reason for Medication:	
3. Possible Side Effects:	
4. Physician/clinic:	

Students who are developmentally and/or behaviorally able, will be allowed to self-administer prescription and nonprescription medication, subject to the following:

1. Permission form must be submitted for self-medication of all prescription and non-prescription medication. Physician or School District Nurse signature needed for prescription medications.
2. All prescription and nonprescription 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, and frequency or time of administration and any other special instructions.
   - Nonprescription medication must have the student's name affixed to the original container.
3. The **amount of medication** to be in the student's possession will depend on the type of medication and will be determined through the approval process.
4. Sharing and/or borrowing of medication with another student is strictly prohibited.
5. Permission to self-medicate may be revoked if the student violates school district policy governing administration of medication and/or these regulations. Additionally, students may be subject to discipline, up to and including expulsion, as appropriate.

I have read and agree to the above criteria. I give permission for my child to carry his/her medication. I give permission for the school district and the student's doctor to exchange information about this medication. **Parent/Guardian Signature:**	**Date:**
I agree to comply with the above criteria. **Student Signature:**	**Date:**
School Administrator Signature:	**Date:**
Physician or School District Nurse Signature (prescription meds ONLY):	**Date:**