Klamath Falls City Schools
100% Graduation is Our Expectation!

Self-Medication Agreement

Student: _____

Medication: _____

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

1) Self-administration of prescription medication requires permission from the parent, school administrator/nurse, **and medical provider** (physician, physician assistant, or nurse practitioner). Medical provider consent for self-administration is to be on the label and/or on treatment plan.

2) The medication must be kept in its appropriately labeled, **original container**, as follows:
-Prescription label on the **original pharmacy container** must specify the name of student, name of medication, dosage, method of administration, and frequency or time of administration and any other special instructions including permission for the student to self-medicate.
-Non-prescription medication must have the student's name affixed to the **original container**.

3) The student may have in his/her possession **only the amount of medication needed for that school day** according to the prescription instructions (with the exception of multiple dose inhalers) or non-prescription packaging.

4) **Sharing and/or borrowing of the inhaler with another student is strictly prohibited.**

5) **Permission to self-medicate may be revoked if the student violates Board policy governing self-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 and give permission for my child to self-medicate. I certify that my child has been instructed in the correct and responsible use of the medication mentioned above. I understand that the **complete policies (JHCD, JHCDA, JHDC-AR)** are at **policy.osba.org/kfalls/index.asp** and the Klamath Falls City School District and its employees **shall not be held liable if the student/family fails to follow district medication policies.**

_____ _____

(Parent/Guardian Signature) (Date)

_____ _____

(Student Signature) (Date)

_____ _____

(School Administrator or Nurse Signature) (Date)