**West Linn-Wilsonville School District**

**Self Medication Agreement**

**Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Prescription  Non-Prescription**

 **(one medication per form)**

**Dose (how much): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student Agreement and Signature:**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree I will**

* Never allow another student to use my medication
* Check to make sure that my medication is labeled with my name
* Be aware of the expiration date of medication and replace before expired
* Keep my medication secure at all times and take to all activities and events as needed
* Avoid/minimize risks to my health and safety by taking the dose according to label instructions
* Follow school protocol and my medical provider’s instruction and directives on my emergency plan of care if applicable
* Report to teacher/coach/administrator/chaperone if I am in distress due to symptoms related to my health which may include
	+ Side effects from medication
	+ Diabetes
	+ Life threatening allergy
	+ Asthma
	+ Other medical concerns

  **Student Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Date\_\_\_\_\_\_\_\_\_\_\_

**Parent Agreement and Signature:**

* If my child carries emergency medication (including but not limited to inhaler, epinephrine auto injector, and/or Glucagon) I am expected to provide “back up” supply in the school health office.
* I will educate (or communicate the need for the school nurse to educate) any/all staff who support my child during extra-curricular activities beyond the normal school day
* Medication will be in original bottle, labeled with student’s name and not be expired
* My child will only have possession of the **necessary** number of doses
* Sharing or borrowing of medication with another student is strictly prohibited
* Permission to self-carry may be revoked if my child violates the District policy
* Violation of this agreement may result in school discipline

 **­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­**

**Parent Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_**

This document will be kept in the Health Office at your student’s school.

Principal Initials \_\_\_\_\_\_\_\_ Nurse Initials \_\_\_\_\_\_\_\_ (revised 8/20/19)