**Sweet Home School District #55**
**Sweet Home, Oregon**

# PERMISSION FOR STUDENT SELF-MEDICATION

Student's Name _____

All prescription and nonprescription medication must be kept in its appropriately labeled, original container. Nonprescription medication must have the student's name printed on the container. **The student may have in his/her possession only the amount of medication needed for that one school day.**

Diagnosis or reason for medication: _____

| Medication | Directions | Time | # of days | Route (by mouth, on skin, etc.) |
|---|---|---|---|---|
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This student has my permission to self-administer the above medication(s):

Parent's signature _____ Date _____

Building principal permission is required for all self-medication requests.
This permission may be revoked if the student violates school policy, medical protocol or treatment plan.

**Sharing and/or borrowing of medication with another student is strictly prohibited.**

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## FOR PRESCRIPTION MEDICATIONS ONLY

## PHYSICIAN AUTHORIZATION

Written authorization and instructions by the prescribing physician are now required by Oregon law for students to carry and self-administer prescription medication during the school day.

☐ Student has demonstrated competency and has my permission to carry and self-administer prescription medication during the school day.

☐ Asthma/allergy action plan attached (if applicable).

☐ Specific instructions (medical protocol or treatment plan) for student to follow when taking this medication at school (required if not included in asthma/allergy plan).

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| _____ | _____ | |
|---|---|---|
| *Physician Name (please print/stamp)* | *Address* | *Zip Code* |
| _____ | _____ | _____ |
| *Physician's Signature* | *Phone Number* | *Date* |