

**GREATER ALBANY PUBLIC SCHOOLS  
SELF-MEDICATION AGREEMENT**

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

1. This Self-Medication Agreement form must be submitted for all self-medication.
  - a. Self-administration of *non-prescription* medication requires this form and permission from a school administrator. (Self-administration of non-FDA approved medication must include a written order from a prescriber)
  - b. Self-administration of *prescription* medication requires this form, and permission from a school administrator and either a RN practicing in the school setting or a prescriber. Prescriber consent can be included on the prescription label or on this self-medication agreement form.
2. All medication must be kept in its appropriately labeled, original container as follows:
  - a. 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.
3. The student *must* have in their possession:
  - a. A copy of this completed form and
  - b. Only the amount of medication needed for that school day except for manufacturer's packaging that contains multiple dosage. The student may carry one package.
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, the student may be subject to discipline, up to and including expulsion, as appropriate if the self-medication policy is violated.

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I have read and agree to the above criteria and give permission to self-administer:

Student Name: \_\_\_\_\_

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

**Please allow this student to self-administer this medication. (Student must be developmentally and behaviorally able to self-administer.)**

Name of medication: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Prescriber or RN Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Required for prescription medications or non-FDA approved OTC)

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\_\_\_\_ This student may carry and self-administer this medication as prescribed

\_\_\_\_ This student may self-administer this medication as prescribed, but the medication will be kept in the office.

School Administrator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_