Harmony Academy
2507 Christie Drive
Lake Oswego, Oregon 97034
Principal Sharon Dursi Martin

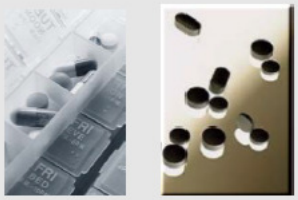
Parent/Guardian Guide for Student Medication at School

The school medication law is designed to protect students and school staff from harm. In order to administer medication to students the following requirements must be met:

1. **Medication must be brought into the school office by a parent/guardian.**
   a. Please do not send medication on the bus or with your child unless specific arrangements have been pre-authorized with Harmony Staff.

2. **Medication must be in the original prescription (non-expired) container.**
   a. If medication needs to be split/cut, it is to be done by the parent/guardian.
   b. If medication needs to be crushed, the parent/guardian needs to send/supply the pill crusher.
   c. If medication needs to be measured, the parent/guardian needs to send/supply the correct tool (such as a measuring teaspoon).

3. **Medication form(s) must be filled out and signed before ANY medication can be administered or brought on-site:**
   a. *Permission for Staff to Administer Medication Form* must be signed by parent/guardian for prescription or non-prescription medications that are to be kept in the main office.
   b. *Student Self-Medication Form* must be signed by parent/guardian, student, and school administrator for medications carried by a student. Prescription medications always require a doctor's signature on the form.

Accepted	NOT accepted
Prescription medication in original container with pharmacy label. If the student has an inhaler, make sure pharmacy label is on the inhaler or is on the box sent with the inhaler. 	**Prescription medication** in a baggie or a medication container without a pharmacy label. Medication in the wrong bottle or in a dose different than it says on the label. 
Over-the-counter medication in original container with the student's name written on it.  ← Student's name written on the side of the box or bottle.	**Over-the-counter medication** in a baggie or container other than original bottle. Dosages not recommended by the manufacturer. 
Medications for current conditions that the student needs to take to be able to participate at school.	Medications "just in case" the student may become ill, vitamins, herbal extracts, etc.

HARMONY ACADEMY
AUTHORIZATION FOR MEDICATION ADMINISTRATION
BY DESIGNATED SCHOOL PERSONNEL

Student Name	Date of Birth	Grade Level

I give school personnel permission to administer this medication per the following instructions:

Medication (Name)	Start Date	Stop Date
Dosage/Strength	Prescription or Non-Prescription	Time(s) of Day to Administer
Frequency	Oral / Ear / Eye / Nose / Topical Method of Delivery (please circle)	
Reason for Medication		
Pharmacy Name	Prescription Number (if applicable)	Prescription Name (if applicable)
Prescriber Phone (if applicable)	Special Instructions	

ALL MEDICATION MUST BE IN ITS UNEXPIRED, ORIGINAL CONTAINER WITH ACCURATE LABEL! NO EXCEPTIONS!

I understand I am responsible to provide this medication and maintain the supply as needed. All medication must be provided from home and must be contained in its original, labeled and unexpired container. I understand that I am responsible to notify the school in writing of any medication changes and that all staff-administered medications are to be brought to and from school by a parent/guardian or student when allowed. All unused medication must be picked up by the last day of school. I understand that any medication left at school will be discarded. (OAR 581-021-0037)

Parent/Guardian (or student) Signature _____ Date _____

PRESCRIBER DIRECTION

(Required in writing or on pharmacy label for all prescription medication and non-FDA approved medications)

- O I have prescribed the above medication for the student whose name appears on the top of the form
- O Instructions from the parent are accurate
- O Please allow this student to carry and self-administer this medication. (Student must be developmentally and behaviorally able to self-administer) (COMPLETE SELF-MEDICATION AGREEMENT)
- O I certify that this medication is necessary for the student to remain in school
- O Special instructions including adverse reactions and action required: _____

Prescriber's Name (please print/stamp)	Prescriber's Signature
Clinic/Facility Name	Clinic/Facility Address
Clinic/Facility Phone Number	Effective Date

HARMONY ACADEMY 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.
2. Self-administration of non-prescription medication requires this form and permission from a school administrator. Self-administration of non-FDA approved medication must also include a written order from a prescriber.
3. Self-administration of prescription medication requires this form and permission from a school administrator and either an 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.
4. All medication must be kept in its appropriately labeled, original container as follows:
5. 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.
6. Sharing and/or borrowing of medication with another student is strictly prohibited.
7. Permission to self-medicate may be revoked if the student violates school district policy governing the 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.

Student Name: _____

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

Name of medication: _____

Signature: _____ Date: _____

I agree to comply with the above criteria:

Signature: _____ Date: _____

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

Prescriber/RN Signature: _____ Date: _____

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

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

School Administrator's Signature: _____ Date: _____