Student Responsibility for Medication Self-Administration

(Please print)
Student Name_____Date of Birth _____Age _____

School _____

To be completed by student

I agree to

1. Never share my medication with another person.
2. Carry the medication in its original, properly labeled prescription/over-the-counter container.
3. Take medication only at the prescribed time/frequency and dose.

- I am knowledgeable regarding the dose, desired effects, side effects, administration, etc., of the medication(s).
- I understand that if I do not comply with this agreement that the medication will be confiscated and returned to my parent/guardian, and my privilege(s) of self-administration/self-possession denied. My physician and parent(s) will be contacted regarding future self-possession.

Student Signature _____Date _____

Parent/Guardian Name _____

Return this form to your school office when complete.

Date Form Received in School Office _____