	Permission for Non-Prescription Medication **School District: Lexington County School District One**	For school use only: ☐ Routine ☐ PRN (As needed) Start Date: __________

When possible, medications should be given to students before or after school by the parent or guardian. Over the counter medications may only be given within the limits of what is printed on the container or the package insert. Medications must be provided to the school by the parent or guardian in the original container. Please note that the school district may reject requests for certain medications to be given at school.

Please complete a separate form for each medication to be given at school. If the medication is to be given to more than one of your children, please complete a separate form for each child.

Child's Name ______________________ Date of Birth ______________

Midway Elementary School
Name of School ______________________ Grade ______________

Is your child allergic to any food, medicines, or other items? ☐ Yes ☐ No
If yes, list allergies.

Name of medication to be given at school:	
Reason for medication:	
Amount of medication to be given:	Time of day medication to be given at school:
Note any special storage requirements: ☐ Refrigerate ☐ Other:	Estimated number of days medication needs to be given at school (choose one): ☐ __________ days ☐ __________ weeks ☐ until the end of the current school year
Does your child take any other medications at home or at school? ☐ Yes ☐ No If yes, what are the medications?	

Child's Health Care Provider's Name and Address:	Office Phone Number:
	Office Fax Number:

I give permission for the medication noted above to be given to my child during the school day. I give permission for the school nurse or school administrator to contact the health care provider named above to discuss this medication and my child's health. I give permission for the health care provider named above or his/her designated employees to share information about this medication and my child's health with the school nurse or school administrator. I understand that the school may require that I agree to the school district's rules about medications before this medicine will be given at school. I understand that I am responsible for notifying the school if any of my child's medications change.

Signature of Parent/Guardian ______________________ Date ______________

Print or Type Name of Parent/Guardian ______________________ Day Phone Number ______________