Healthy Children Learn Better	**Permission for Prescription Medication** **School District: Lexington County School District One**	For school use only: □ Routine □ PRN (As needed) Start Date: _____

Child's Name _____ Date of Birth _____

Midway Elementary School

Name of School _____ Grade _____

Medication:	Dosage:
Purpose of Medication:	Route:

When possible, medications should be administered by a parent or guardian before or after school hours. Initial doses of a medication that the child has never taken before should not be given at school. Medication to be given at school must be provided to the school in the original labeled container provided by the pharmacist who filled the prescription. "Sample" medications must be provided in a container that appropriately identifies the medication and must be accompanied by a note signed and dated by the prescribing health care provider that includes the student's name, directions for proper administration, and the name, address, and phone number of the prescribing health care provider.

Time of day medication to be given at school:
Please note that lunch times vary (10:30 A.M. — 1 P.M.).

Anticipated number of days medication needs to be given at school:

☐ until end of current school year

☐ ____ weeks

☐ ____ days

Is this medication a controlled substance? ☐ No ☐ Yes

Note any special storage requirements:

☐ Refrigerate ☐ Other:

Possible Side Effects:

Prescribing Health Care Provider's Signature _____ Date _____

Type or Print Prescribing Health Care Provider's Name _____

Health Care Provider's Address:	Office Phone Number
	Office Fax Number

Section below to be completed by child's parent or guardian:

I give permission for my child, _____, to be given the above medication as prescribed. I give permission for the school nurse or school administrator to contact the health care provider named above or the pharmacist who filled the prescription to discuss this medication and my child's health. I give permission for the health care provider named above, the pharmacist, and/or their designated employees to share information about this medication and my child's health with the school nurse or school administrator. I also give permission for this "Permission for Prescription Medication" to apply if I transfer my child to another school in this same school district during this same school year. 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 my child's medications change in any way.

Signature of Parent/Guardian _____ Date _____

Print or Type Name of Parent/Guardian _____ Day Phone Number _____