Permission for School Administration of Non-Prescription and Prescription Medication

Lexington County School District One

For school use only:

☐ Routine

☐ PRN (As needed)

Start Date: _____

Whenever possible, parents/guardians should give their children their medications before or after school hours. The school nurse should not give your child the first or initial dose of any medication that he or she has never taken before. Please do that at home.

In order for your child to receive any prescription or non-prescription medication, you must completely fill out one of these forms for each medicine, including the prescribing health care provider's signature and directions from that health care provider for proper administration, and give it to the school nurse. The medication, whether prescription or non-prescription, must be in its original labeled container. If you were given "samples" of any medications, they must also be in a container that appropriately identifies the medication.

The following section is to be completed by the prescribing health care provider.

_____ _____

Child's Name Date of Birth

_____ _____

Name of School Child Attends Grade

Medication:		Dosage:
Purpose of Medication:		Route:
Time medication to be given at school: (Lunch times vary from 10:30 a.m.–1 p.m.)	Frequency (e.g., daily):	Note special storage requirements ☐ None ☐ Refrigerate ☐ Other (please specify)
Anticipated number of days medication will be given at school: ☐ until end of current school year ☐ _____ weeks ☐ _____ days		Is child allergic to any food, medicines or other items? ☐ No ☐ Yes (List allergies.) Is this medication a controlled substance? ☐ No ☐ Yes
Possible Side Effects:		

_____ _____

Prescribing Health Care Provider's Signature Date

Stamp, Print or Type Health Care Provider's Name and Address:	Office Telephone Number
	Office Fax Number

The following section is 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 provide information about this medication and my child's health to the school nurse or school administrator. I also give permission for this form to apply if I transfer my child to another school in Lexington District One during the current school year. I will not hold the school, school district or school personnel liable for any adverse drug reactions when the medication is administered according to the prescribed methods. I agree to notify the school if my child's medication changes.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Print or Type Name of Parent/Guardian Day Telephone Number