Permission for School Administration of Non-Prescription and Prescription Medication

Lexington County School District One

School Year: _____

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 (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 medication and give it to the school nurse. **A physician order is required for all prescription medications, all over the counter (OTC) medications that will be administered for >14 consecutive days, all OTC medications outside of the manufacturer's recommendations, and all herbal, dietary or homeopathic supplements or remedies**. All medication must be in its original labeled container. If you were given "samples" of any medications by your health care practitioner, those samples must also be in a container that appropriately identifies the medication.

By signing this form, the parent/guardian and health care practitioner acknowledge that information from this form may be included in the student's Individual Health Care Plan, if applicable. Medications and/or treatments may be administered by an unlicensed, trained district employee.

Child's Name _____ Date of Birth _____

Name of School Child Attends _____ Grade _____

The following section is to be completed by the prescribing health care practitioner for all prescription medications, all OTC medications that will be administered for >14 consecutive days, all OTC medications outside of manufacturer's recommendations, and all herbal, dietary or homeopathic supplements or remedies.

Medication:	Strength:	Dosage:
Indication for medication/Symptoms to treat:	ICD-10 Code:	Route:
Time medication to be given at school: (Lunch times vary from 10:30 a.m.–1 p.m.)	Frequency (e.g., daily):	**ALLERGIES:** (food, insect, medication, etc.)
Anticipated number of days medication will be given at school: ❑ until end of current school year ❑ _____weeks ❑ _____days ❑ _____other (please specify): _____		Note special storage requirements ❑ None ❑ Refrigerate ❑ Other (please specify) Is this medication a controlled substance? ❑ No ❑ Yes
Possible Side Effects:		

Prescribing Health Care Practitioner's Signature _____ Date _____

Stamp, Print or Type Health Care Practitioner'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 to contact the health care practitioner named above or the pharmacist who filled the prescription to discuss this medication. I give permission for the health care practitioner named above, the pharmacist and/or their designated employees to provide information about this medication and my child's health to the school nurse. I also give permission for this form to apply if I transfer my child to another school in Lexington County School 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 _____