Permission for School Administration of Prescription Medication **School Year:** _____	For school use only: ❑ Routine ❑ PRN (As needed) Start Date:_____

When possible, medications should be administered by the parent/guardian before or after school hours. The first dose of any medication that your child has not taken before will not be given during school hours. Prior to your child receiving any prescribed medications during the school day, this form must be completed with prescribing physician's signature and the signature of the parent/guardian for each medication. In order for the school nurse to comply with the medication order, the medication must be in its original labeled container by the pharmacy. If you receive "Sample" medications from your health care provider, the sample medications must be in a container that appropriately identifies the medication and your child.

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.

_____ _____
Child's Name Date of Birth

_____ _____
Name of School Child Attends Grade

Is child allergic to any food, medicines, or other items? ❑ No ❑ Yes (List allergies.)

Medication:		Medical Diagnosis:	ICD-10 Code:
Dosage:	Route:	Frequency: (e.g., daily)	Time medication to be given at school:
Anticipated number of days medication will be given at school: ❑ until end of the current school year ❑ _____weeks ❑ _____days ❑ until end of Summer School for the current school year		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 or school administrator to contact the healthcare practitioner named above or the pharmacist who filled the prescription to discuss this medication and my child's health. I give permission for the healthcare 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 or school administrator. I also give permission for this form to apply if I transfer my child to another school in Richland County School District One during the current school year and Summer School. 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 method. I agree to notify the school if my child's medication changes or changes with my contact information.

_____ _____
Signature of Parent/Guardian Date

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