

Permission for School Administration of Prescription and Non-prescription Medication Form

Lexington County School District Two

For school use only:

- Routine
 PRN (As needed)

Received Date: _____

Start Date: _____

Medications should be administered by a parent or guardian before or after school hours, when possible. Initial doses of a medication that a child has never taken before will not be given at school. Medication to be given at school should be accompanied by this form, complete with the prescribing physician's signature, and provided to the school in the original labeled container. "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 and directions for proper administration.

Child's Name _____

Date of Birth _____

Name of School _____

Phone _____

Fax _____

Grade _____

This section to be completed by prescribing health care provider:

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

Prescribing Health Care Provider's Signature _____

Date _____

Health Care Provider's Name & Address:

Phone Number _____

Fax Number _____

This section to be completed by child's parent or guardian:

I give permission for the School Nurse (or trained Unlicensed Assistive Personnel) to give my child 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 "Permission for School Administration of Prescription and Non-Prescription Medication" form to apply if I transfer my child to another school in this same school district during the current school year. I understand that the school will require that I agree to the school district's rules about medications before this medicine will be given at 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 methods. I will notify the school if my child's medications change.

Signature of Parent / Guardian _____

Date _____

Print or Type Name of Parent / Guardian _____

Day Phone Number _____