Healthy Children Learn Better

Permission for School Administration of Prescription Medication

School District: Spartanburg County School District 3

For school use only:
☐ Routine
☐ PRN (As needed)
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 should 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 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.

Child's Name _____ Date of Birth _____

Name of School _____ Grade _____

Medication:	Dosage:
Purpose of Medication:	Route:
Time of day medication to be given at school: If possible, please specify preferred time. Lunch times vary (10:30a – 1p).	Note any 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 & 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 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 Prescription Medication" 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 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 _____

Healthy Children Learn Better	**Permission for School Administration of Non-Prescription Medication** **School District:** Spartanburg County School District 3	For school use only: ☐ Routine ☐ PRN (As needed) Start Date: _____

When possible, medications should be given to students before or after school by the parent or guardian. Over the counter medications may only be given within the limits and according to the instructions printed on the container or the package insert. Medications must be provided to the school by the parent or guardian in the original container. Please note that the school district may reject requests for certain medications to be given at school.

Please complete a separate form for each medication to be given at school. If the medication is to be given to more than one of your children, please complete a separate form for each child.

Child's Name _____ Date of Birth _____

Name of School _____ Grade _____

Is your child allergic to any food, medicines, or other items? ☐ No ☐ Yes (If yes, list allergies.)

Name of medication to be given at school:

Reason for medication:

Amount of medication to be given:	Time of day medication to be given at school:
Note any special storage requirements: ☐ Refrigerate ☐ Other (please specify)	Estimated number of days medication will be given at school (choose one): ☐ _____ days ☐ _____ weeks ☐ until the end of the current school year

Does your child take any other medications at home or at school? ☐ No ☐ Yes (If yes, what are the medications?)

Child's Health Care Provider's Name and Address (please print):	Office Phone Number: Office Fax Number:

I give permission for the medication noted above to be given to my child during the school day. I give permission for the school nurse or school administrator to contact the health care provider named above to discuss this medication and my child's health. I give permission for the health care provider named above or his/her designated employees to provide information about this medication and my child's health to the school nurse or school administrator. 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 any of my child's medications change.

Signature of Parent / Guardian _____ Date _____

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