Permission for School Administration of Medication

Important Information: Please read this prior to completing the "Permission for School Administration of Medication" form.

Important Information About Medications in School Settings
1. When possible, medications should be given at home by the parent/guardian. 2. Medications are given within 30 minutes before or after the ordered time as designated by the student's health care provider. In the event of a delayed start to the school day, any morning medications given at school will need to be given at home as the school nurse will not be able to administer. 3. Initial doses of a medication that a child has never taken before should not be given at school. 4. A written prescription is **REQUIRED** for Prescription, Herbal, Homeopathic, or OTC Medications with dosage outside of manufacturer's recommendations to be given in South Carolina's school settings. The "Permission for School Administration of Medication" form, when signed by an authorized prescriber, may serve as the written prescription. 5. Any medication that the nurse has received a healthcare provider's order, is to be treated as a prescription medication and must have a pharmacy label on the bottle in order to administer. 6. A parent's/legal guardian's authorization/signature is also required. 7. A separate form must be completed for each medication. 8. Space for medication storage in school settings is limited; therefore, to the extent possible medication quantities to be stored at school should be limited. a. Controlled substances must be limited to no more than a 31-day supply. b. If it is necessary to store an over-the-counter medication at school, small containers of the medication should be purchased and provided to the school. 9. Prescriptions, if needed, for over-the-counter medications: c. should be for specific conditions that a child is known to experience (e.g. menstrual cramps, headache not due to injury), d. should be a medication that the prescribing health care practitioner has deemed appropriate based on the child's medical history, and e. the substitution permitted box must be checked by the authorized prescriber if generic medication is to be administered. 10. Prescriptions must be renewed, at a minimum, at the beginning of each school year. 11. Schools may decline to administer certain medications if deemed inappropriate for a school setting. In that event, the parent and the health care practitioner will be notified. 12. Medications for the purpose of treating a fever, defined as a body temperature elevation, will only be administered at school as part of an emergency response for students with certain chronic health conditions. 13. Medications that make students drowsy and unable to participate in educational activities may not be appropriate for school administration. 14. For over-the-counter medication use, a school nurse may use her/his clinical judgment with regards to whether it is best to administer the over-the-counter medication or provide non-medicinal interventions. 15. A responsible adult should deliver the medicine and the permission form to the school. The medicine must be in the original container with the pharmacy label or in the case of over-the counter medications the manufacturer's label on it. 16. After school programs operated by third parties (e.g. the Boys and Girls Club) will not have access to medications provided to the school under the "Permission for School Administration of Medication" form. All necessary medications, including emergency medication (e.g. epi-pens, inhalers, etc.) must be provided separately to the after school program operator.

Permission for School Administration of Medication

School District: NEWBERRY COUNTY SCHOOL DISTRICT

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 if required, 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.

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 (IHP), if applicable. If all of the treatment plan or medical orders will be followed by the school as written and the IHP is consistent with the treatment plan or medical orders, the signature of the Health Care Practitioner and the student's parent/guardian on the IHP will not be required. The IHP will be shared with other school staff who have a legitimate need for knowledge of the information.

This section to be completed by the prescribing health care provider:

Child's Name ______________________ Date of Birth ____________

Name of School ______________________ Grade ____________

Medication: ☐Substitution permitted		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 ☐ None ☐ Refrigerate ☐ Other (please specify)
		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:		

PLEASE LIST ICD-10 DIAGNOSIS CODE FOR THIS STUDENT'S CONDITION: ICD-10 CODE ______________

Prescribing Health Care Provider's Signature ______________________ **Date** ____________

REQUIRED for Prescription, Herbal, Homeopathic, or OTC Medications with dosage outside of manufacturer's recommendations.

Stamp, Print or Type Health Care Provider's Name & Address	Office Phone Number
	Office Fax Number

This section 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 School Administration of 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 may require that I agree to the school district's rules about medications before this medicine will be given at school. I further understand that any after school program not operated by the school or school district (e.g. the Boys and Girls Club) will not have access to the medications described above, and that it is my responsibility to provide the operator of the after school program with any necessary medication and training, including emergency medication, for my child. 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. If an IHP is developed that encompasses these medical orders, I understand this plan of care is for my child while he or she is at school or is attending school-sponsored functions. I agree to notify the school of changes in my child's health condition, medication and/or contact information. I understand that I will receive a copy of my child's IHP if one is developed. I give permission for a trained Unlicensed Assistive Personnel (UAP) to assist my child with medication in the absence of the school nurse.

Signature of Parent / Guardian ______________________ Date ____________

Print or Type Name of Parent / Guardian ______________________ Day Phone Number ____________