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.

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. I will notify the school if my child's medications change. 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