HILTON HEAD CHRISTIAN ACADEMY *College Preparatory Christian School*	**Prescription Medication Authorization** School Year: _____	**For school use only:** ☐ Routine ☐ PRN (as needed) ☐ Self-administer

This form must be completed annually by the child's prescriber and parent/legal guardian.

Please note the following:

1. Medication should be administered by a parent/guardian before or after school hours, when possible.
2. All prescribed medications must be provided to the school in a current, original labeled container issued by the pharmacy who filled the prescription and accompanied by this form.

Child's Full Name:	**Date of Birth:** **Grade:**	**Gender:** ☐ Male ☐ Female

Section below must be completed by the Child's Health Care Provider:

Name of Prescribed Medication:		**Purpose of Medication:**	
Prescribed Dose:	**Prescribed Route:**	**Controlled Substance:** ☐ No ☐ Yes	**Special Storage Required:** ☐ No ☐ Yes _____
Time of day Medication is to be given at school: *(Please specify preferred time. "Lunch" times vary from 10:30am-1:30pm)*		**Number of days Medication will be given at school:** ☐ until the end of the current school year ☐ _____ day(s) ☐ _____week(s)	
List possible side effects from this Medication:			
Does this child have any known allergies? ☐ No ☐ Yes (If yes, list all known allergies and reactions)			
Name of Health Care Provider:		**Office Phone#:**	**Office Fax#:**
Health Care Provider's Signature:			**Date:**

Section below must be completed by the Parent/Legal Guardian:

I agree with all of the following:

- I give permission for my child to be given the above medication as prescribed while at school.
- I give permission for the school nurse or designated trained UAP to contact the prescriber, the pharmacist who filled the prescription, or their designee to discuss this medication and my child's health.
- I give permission for the health care provider, pharmacist, and/or their designee to provide information about this medication and my child's health to the school nurse or administrator.
- I further give permission for information about my child to be shared with persons who legitimately need to know for the safety and well-being of my child.
- I agree to follow HHCA rules concerning medications.
- I agree that the medication will be given per HHCA policy.
- I agree I am responsible for providing school with the medication for my child and any supplies needed.
- I agree that I am responsible for notifying the school if my child's medication(s) change in any way.

Printed Name of Parent/Legal Guardian:	**Signature of Parent/Legal Guardian:**
Daytime Phone#:	**Date:**

I would like my child to be considered to self-administer the above medications. Only epi-pens, inhalers or special medications by nurse approval may be self-administered. Controlled substances are never considered for self-administration. ☐ Yes ☐ No ☐ N/A