Florence 1 Schools
Students first

Permission for School Administration of Medication

(This form must be completed by the child's Prescriber and Legal Guardian.)

Please be aware of the following requirements:

1. Medication must be brought to the school nurse by a responsible adult. (Do not send with a child.)
2. Medication should be administered by a parent/guardian before or after school hours, when possible.
3. All prescribed medications must be provided to the school in the original labeled container issued by the pharmacist and accompanied by this permission form. (the label and the prescriber's order on this form must match)
4. Any prescribed controlled substance must be brought to the school nurse by the parent when the prescription is filled each month and must be provided to the school nurse in the most recent pharmacy labeled container.
5. "Sample" medication must be provided in a container that appropriately identifies the medication and must be accompanied by a note signed and dated by the prescribing provider that includes the student's name and directions for proper administration, along with this permission form.
6. Starting doses of a medication that a child has never taken before will not be given first at school.
7. F1S district may reject requests for certain medications to be given at school.
8. This form will apply if the child transfers to another school within F1S district.

Child's Full Name:	**Date of Birth:**
Gender: Male or Female	**Grade Level / Teacher:**

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

Name of **Prescription Medication** to be given at school**:**		**Reason(s)** for this Medication to be given at school**:**
Prescribed **Dose/Strength:** (i.e. 50 mg, mcg, grams)	**Amount** to be given at School**:** (i.e. 1 tab, 5 ml, 0.5 tab, 2 puffs)	**Frequency/Time** to be given at school**:** (Please specify preferred time. "Lunch" times vary from 10:30 am -1:00 pm)
Prescribed **Route**:	**Controlled Substance:** ☐ No ☐ Yes	**Number of days medication** is to be given at school**:** ☐ until the end of the current school year ☐ day(s) ☐# week(s)
List **possible side effects** from this medication**:**		**Special Storage Required:** ☐ No ☐ Yes

Prescribing Health Care Provider's Name & Office: ***(please print or stamp)***

Office Phone/Fax: _____

Signature of Prescriber: _____ ***Date:*** _____

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

Does this child have **any known allergies?** ☐ No ☐ Yes

(If yes, list all known allergies and type of reaction(s):

Does this child **take any additional medications at home or at school?** ☐ No ☐ Yes

(If yes, list the medications taken at home):

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 information about this medication and/or my child's health to be exchanged between the F1S school nurse or designated F1S employee and/or the Health Care Provider, the prescriber, the pharmacist who filled this prescription, and/or their designee.
- 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 the F1S rules concerning medications.
- I agree that the medication will be given per the F1S district's policy.
- I agree I am responsible for providing the 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.

Parent/Guardian's Name (Print) **Parent/Guardian Signature** **Date** **Daytime Phone**

***This form is only valid if signed on or after July 1 for the upcoming school year.

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