DARLINGTON COUNTY SCHOOL DISTRICT	**Permission for School Administration of Medication** **School District: DARLINGTON COUNTY SCHOOL DISTRICT**	For school use only: Start Date: _____

1. Medications should be administered by a parent or guardian before or after school hours, when possible.
2. Initial doses of a medication that a child has never taken before will not be given at school.
3. Medication to be given at school must be accompanied by this form, completed entirely.
4. Medication must be provided to the school nurse in the most recent original labeled container.
5. The label and the prescriber's order on this form must match.
6. A separate form must be completed for each medication.
7. Medication must be brought to the school nurse by a responsible adult. **Students are not allowed to transport medication to or from school.**

Section below must be completed by a Licensed Healthcare Provider

Student's Legal Name:		Date of Birth:
Medication:		Dosage:
Purpose of Medication:		Route:
Time medication to be given at school: (specify time. Lunch times vary: 10:30a – 1:30p)	Frequency: (e.g., daily)	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 ☐ ____ overnight field trip only ☐ summer enhancement program		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 _____

Student has permission to carry life saving medication and has demonstrated competency: YES/NO

_____ _____

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

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 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 agree to follow DCSD medication guidelines. ***Failure to adhere may result in suspension and viewed as medical neglect.***
- I acknowledge that the school district and its employees and agents are not liable for any injury arising from administration of medication according to prescribed methods and/or authorized by an IHP/ health care practitioner and shall indemnify and hold harmless the district and its employees and agents against a claim arising from administration of medication according to prescribed method and/or authorized by an IHP/health care practitioner.
- I agree to notify the school of changes in my child's health condition, medication and/or contact information.
- 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