Hilton Head Christian Academy

Prescription Authorization Form

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/legal 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 (circle one):** Male / Female

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Section below must be completed by the child's healthcare provider.

Name of Prescribed Medication: _____ **Purpose of Medication:** _____

Prescribed Dose: _____ **Prescribed Route:** _____

Controlled Substance? Yes / No **Special Storage Required?** Yes / No _____

Time medication is to be given *(Please specify specific time. "Lunch" times vary from 10:15-12:30 PM):* _____

Medication will be given: ____ at school ____ on retreat

List possible side effects from medication: _____

Does this child have any known allergies? Yes / No *(If YES, list all known allergies and reactions):* _____

_____

Name of healthcare provider and practice: _____

Practice Name:_____ **Office Phone:** _____ **Office Fax:** _____

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 on Retreat.*
- *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 healthcare 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.*

Section below must be completed by the parent/legal guardian.

Printed name of parent/legal guardian: ***Signature of parent/legal guardian:***

_____ _____

Parent Cell: _____ ***Date:*** _____

I would like my child to be considered to self-administer the above medication(s). 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*