Spartanburg School District 4
Permission for School Administration of Non-Prescription Medication

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. Over the counter medications may only be given within the limits and according to the instructions printed on the container or the package insert. Medications must be provided to the school by the parent or guardian in the original container. Please note that the school district may reject requests for certain medications to be given at school.

_____ _____
Child's Name Date of Birth

_____ _____
Name of School Grade

Medication:	Dosage:
Purpose of Medication:	Route:
Time of day of medication to be given at school:	Note any special storage requirements: ☐ None ☐ Refrigerate ☐ Other (please specify):
Anticipated number of days medication will be given at school: ☐ until the end of current school year ☐ _____ weeks ☐ _____ days	Is the child allergic to any food, medicines, or other items? ☐ No ☐ Yes (List allergies): Is this medication a controlled substance? ☐ No ☐ Yes
If your child takes any other medications at school or home, please list below.	

Child's Health Care Provider's Name & Address (please print):	
	Office Phone Number
	Office Fax Number

Section below 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 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 understand that I am responsible for notifying the school if my child's medications change in any way.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Print or type name of Parent/Guardian Day phone number