Prescription Medication
Permission for School Administration

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

Please note the following:

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 who filled the prescription and accompanied by this form.
4. "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 the permission form.
5. Starting doses of a medication that a child has never taken before should not be given first at school.
6. HCS district may reject requests for certain medications to be given at school.
7. This form will apply if the child transfers to another school within HCS district.

Child's Full Name:		**Date of Birth:**	**Gender:** □ Male OR □ Female
Grade:	**Homeroom Teacher:**	**Name of School:**	
Section below must be completed by the Child's Health Care Provider:			
Name of Prescribed Medication:		**Purpose for 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 10:30a-1p)		**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)			
Child's Health Care Provider's Name and Office Address (print or stamp): **Office Phone:** _____ **Office Fax:** _____			
_____ **Health Care Provider's Signature**	_____ **Date:**		
Section below must be completed by the Parent/Legal Guardian:			
Does your child take any additional medications at home or at school? ☐ No ☐ Yes (If yes, list the medications)			

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 HCS school nurse or designated HCS employee 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 HCS 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 the HCS rules concerning medications.
- I agree that the medication will be given per the HCS district's 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.

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