

Prescription Medication

Permission for School Administration

must be completed by the child's prescriber and parent/guardian

For HCS Nurse use:
 Entered
 Scanned
 IHP
 EAP

Please read the following:

1. Medication should be administered by a parent/guardian before or after school hours, when possible.
2. First doses of a medication that a child has never received will not be given at school.
3. Medication must be brought to the school nurse by a responsible adult. **(Do not send medication in with a child.)**
4. 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)**
5. Prescribed controlled substances must be provided to the school nurse when the prescription is filled each month and must be in the most recent pharmacy labeled container. HCS can only accept a 30-day supply of controlled substances.
6. "Sample" medication must be provided in a container appropriately labeled, which 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.
7. Herbal substances are not considered medication and will not be administered by the school nurse.
8. HCS district may reject requests for certain medications to be given at school.
9. This form is still valid and in effect if the child transfers to another school within HCS district for the current school year.
10. You **MUST** complete a **separate form for each medication** that is to be given at school.

Child's Full Name: _____ **Grade Level:** _____

Date of Birth: _____ **Gender:** Male or Female

Section below must be completed and signed by the child's Licensed PRESCRIBER:		
Name of Prescription Medication to be given at school:		Reason(s) for this Medication to be given at school:
Prescribed Dose/Strength: <small>(i.e. 50 mg, mcg, grams)</small>	Amount to be given at School: <small>(i.e., 1 tab, 5 ml, 0.5 tab, 2 puffs)</small>	Prescribed Time or Frequency to be given at school: <small>(For time, please be specific as "Lunch" times vary from 10:30a-1p)</small>
Prescribed Route:	Controlled Substance: <input type="checkbox"/> No <input type="checkbox"/> Yes	Number of days medication is to be given at school: <input type="checkbox"/> until the end of the current school year <input type="checkbox"/> ____ day(s)
List possible side effects from this medication:		Special Storage Required: <input type="checkbox"/> No <input type="checkbox"/> Yes _____

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

Fax: _____

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

**Please note: This form is only valid if signed and dated on or after July 1 for the upcoming school year.*

Section below must be completed and signed by the PARENT / LEGAL GUARDIAN:
Does this child have any known allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>(If yes, list known allergies and type of reaction(s): _____)</small>
Does this child take any additional medications at home or at school? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>(If yes, list the medications taken at home): _____</small>

By signing below, I understand and agree to the following:

- I have read and understand statements numbered 1 through 10 at the top of this form.
- I agree to follow the HCS district policies concerning medications.
- I agree for my child to be given the above medication as prescribed while at school per HCS district's policies.
- I agree for information about this medication and/or my child's health to be exchanged between the HCS school nurse or designated HCS employee and/or the Health Care Provider, the prescriber, the pharmacist who filled this prescription, and/or their designee.
- I agree for information about my child to be shared with those who legitimately need to know for the safety and well-being of my child.
- I agree that it is my responsibility to provide the school with the medication for my child and any supplies needed.
- I agree that it is my responsibility to notify the school if my child's health and/or medication(s) change in any way.

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

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