ONLY ONE MEDICATION PER PAGE/ PERMISSION FORM

RICHLAND SCHOOL DISTRICT TWO	**MEDICATION PERMISSION FORM** **School Year 2024- 2025** **School Name _____**	**For School Use:** **__ Routine** **__ Prn** **Start Date _____**

Medications should be administered by a parent or guardian before or after school hours, when possible. Initial doses of a medication that a child has never taken before will not be administered at school. Prescription medication to be administered at school should be accompanied by this form, complete with the prescribing healthcare provider's signature, and provided to the school in the original labeled container provided by the pharmacist who filled the prescription. "Sample" medications must be provided in a container that appropriately identifies the medication and must be accompanied by a note signed and dated by the prescribing healthcare provider that includes the student's name, directions for proper administration, and the name, address, and phone number of the prescribing health care provider. As needed medications must have parameters for medication usage. Non-prescription medications will be administered with a parent's written permission according to the directions on box, etc.

Child's Name	**Date of Birth**	**Grade ____**	**Teacher_____**
Medication Name: one medication/ page	**Dosage:**	**Route:**	
Diagnosis/ Reason for Medication: **ICD 10 Code**	**Time Medication is due:**	**Frequency of Medication:**	
Parameters for prn medications (e.g. for braces pain, menstrual cramps, headache, etc.)		**Special Storage requirements (please specify)**	
Does the student have any Severe Allergies? **☐ No ☐ Yes- please list _____**		**Is this medication a Controlled Substance?** **☐Yes ☐No**	
Side Effects: _____		**Anticipated number of days medication will be given at school:** **☐ until end of school year ☐ ___ days ☐ ___ weeks**	
Prescribing Healthcare Providers Signature _____	**Printed Name** _____	**Date:** _____	
Healthcare Providers Address:	**Phone: _____** **Fax: _____**		

Section Below to be completed by Parent or Guardian:

I give permission for my child, _____, to be administered 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 also give permission for this "Permission for Medication" to apply if I transfer my child to another school in this same school district during the current school year. I understand that the school may require that I agree to the school district's rules about medications prior to the administration of this medication. I understand that I am responsible for notifying the school if my child's medications change in any way. I give permission for a health aid or other designee to assist my child with medication in the absence of the RN.

Signature of Parent _____	**Date:** _____
Printed Name _____	**Daytime Phone:** _____