2024 - 2025

Horry County Schools

Prescription Medication

Permission for School Administration

HCS Nurse use:
Entered ☐ IHP ☐
Upload ☐ EAP ☐
Print PS ☐

Please read the following:

1. HCS District may reject requests for certain medication(s) to be given at school.
2. The **parent/guardian is responsible for administering morning and/or after school doses** of medication(s) unless there is a special circumstance. Special circumstances will need to be discussed with the HCS nurse prior to implementation.
3. The **first dose** of a new medication that a child has never received will not be given at school.
4. **Herbal substances and other Supplements** are not considered medication and will not be administered.
5. Prescribed medications must be provided to the school in the original labeled container issued by the pharmacist and accompanied by this completed form. **The prescription label and the prescriber's order on this form must match.**
6. HCS can **only accept a 30-day supply of prescribed controlled substances.** These must be provided to the school nurse when the prescription is filled each month and must be in the most recent pharmacy labeled container.
7. *"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.
8. This form is still valid if the student transfers to another school within the HCS District during the current school year.
9. You must complete a separate form for each medication that is to be given at school.
10. **Do not send medication in with a child.** (Medication must be brought to the school nurse by a responsible adult.)

Student's Full Name: _____

Date of Birth: _____ **Grade Level:** _____

Licensed Prescriber must complete the following section:	*(This form and Rx label must match)*
Name of **Prescription Medication** to be given:	**Reason(s)** for this medication to be given at school:
Prescribed **Dose** - Amount to be given at school: (i.e. 5 mg, 90 mcg; 5 ml, ½ tab, 2 puffs)	**Prescribed Time or Frequency** to be given at school: (For time, please be specific as "Lunch" times vary from 10:30a-1p)
Prescribed **Route** medication is to be given at school:	**Number of days** medication is to be given at school: ☐ until the end of this school year ☐ _____ day(s)
List **possible side effects:**	

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

_____ Fax: _____

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

**To be valid for the school year this form must be signed and dated on or after July 1st*

Parent/Legal Guardian must complete the following section:

List any **known allergies** and the type of reaction(s) this child has: _____

List any **additional medications** this child takes at home or at school: _____

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 request and agree for my child to be given the above medication as prescribed while at school.
- I agree for information about this medication and my child's health to be exchanged between the HCS nurse or designated HCS employee and/or the provider, the prescriber, the pharmacist, or their designee.
- I agree for information about my child to be shared with those who legitimately need to know for their well-being.
- I agree that I am responsible for providing the school with the medication and any supplies needed for my child.
- I agree that I am responsible for notifying the school if my child's health and/or medication(s) change in any way.

_____	_____	_____	_____
Signature of Parent/Legal Guardian	***Today's Date***	***Phone Number***	***Relationship to Student***

HCS Med Review by: Nurse 1 _____ Nurse 2 _____ *(sign & date)* Rev 4/2024