2025 – 2026

Horry County Schools

(OTC) Non-Prescription Medication

Permission for School Administration

(This form must be completed by the student's Parent/Guardian.)

HCS NURSE USE:
ENTER ☐ IHP ☐
UPLOAD ☐ EAP ☐
PRINT PS ☐

Please note:

1) The **parent/guardian is responsible for administering morning and/or after-school doses** of medication(s) unless there is a special circumstance. Special circumstances must be discussed with the HCS nurse before implementation.
2) HCS District may reject requests for certain medication(s) to be given at school. The **first dose** of a new medication that a child has never received will not be given at school. **Herbal substances and other Supplements** are not considered medication and will not be administered.
3) **Non-Prescription**, also known as **Over the Counter (OTC*)*** medications may **only be given within the limits and according to the manufacturer's instructions**. If the OTC medication is to be given outside of the recommended manufacturer's guidelines, a Physician's order will be required and then it is considered a prescription medication.
4) **Over the Counter (OTC)** medications must be delivered to the school by the parent/guardian or responsible adult designee in the **unopened, original container with the label** from manufacturer**.** (**Bring a small unopened bottle.) Do not send medication in with a child.**

Student's Name: _____ **Birthdate:** _____ **Grade:** _____

This must be completed by the student's Parent/Legal Guardian:

Name of **Non-Prescription Medication** to be given**:**	**Reason(s)** for this medication to be given at school**:**
Dose / Amount to be given at school**:** (must be within the limits of the manufacturer's instructions)	**Frequency** to be given at school**:** (must be within the limits of the manufacturer's instructions)

Number of days medication is to be given at school**:** ☐ until the end of this school year OR ☐ _____ day(s)

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

- I request and agree for my child to be given the above medication while at school.
- I am responsible for providing the school with the medication and any required supplies for my child.
- I agree to follow the HCS district policies concerning medications.
- I agree for information about this medication and/or my child's health to be exchanged between the HCS nurse or designated HCS employee and/or my child's Health Care Provider or designated personnel.
- I agree for information about my child to be shared with those who need to know for their safety and well-being.
- I understand it is my responsibility to notify the school if my child's health and/or medication(s) change in any way.
- The school district and its employees and agents are not liable for any injury arising from the administration of authorized medication.
- The parent/guardian shall indemnify and hold harmless the district and its employees and agents against a claim arising from administration of authorized medication.

_____	_____	_____	_____
Signature of Parent/Guardian	***Relationship to Student***	***Date***	***Phone Number***

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

HCS NURSE USE				
	MEDICATION VERIFICATION	HCS NURSE 1:	DATE:	MEDICATION EXPIRATION DATE:
		HCS NURSE 2:	DATE:	
	MEDICATION PICK UP / DISPOSAL	☐ DISPOSED OF MEDICATION PER SCDPH GUIDELINES. ☐ PICKED UP BY:	DATE:	