FMSD FORT MILL SCHOOL DISTRICT	**Fort Mill School District #4** **Permission for School Administration** **Of All Medications**	For School Use Only: □ Routine □ PRN Start Date:_____

When possible, medications should be given to students before or after school by the parent or guardian. Over the counter medications may only be given within the limits and according to the instructions printed on the container or the package insert. Medications should be provided and transported to and from the school by the parent or guardian in the original container. Please note that the school district may reject requests for certain medications to be given at school.

A physician order is required for all prescription medications, all over the counter (OTC) medications that will be administered >14 consecutive days, and all OTC medications outside of the manufacturer's recommendations.

Please complete a separate form for each medication to be given at school. If the medication is to be given to more than one of your children, please complete a separate form.

_____ _____ _____
Child's Name Date of Birth Grade

Is your child allergic to any food, medicines, or other items? □ No □ Yes (If yes, list allergies)	
Name of Medication:	Is this medication a controlled Substance? □ NO □ YES
Specific Reason for medication:	Check appropriate box: □ # of days to administer_____ □ Until end of school year
Amount/Dose of medication to be given:	Time of day medication to be given at school:

Child's Health Care Provider's Name and Address (please print):	Office Phone Number:
Provider Signature : (Prescription medications ONLY)	Office Fax Number:

I give permission for the medication noted above to be given to my child during the school day. I give permission for the school nurse or designated school official to contact the health care provider, pharmacist or his/her designated employees to discuss this medication and my child's health. I give permission for the health care provider named above, pharmacist or his/her designated employees to provide information about this medication and my child's health to the school nurse or designated school official. I understand that I am responsible for notifying the school if any of my child's medications change.

I understand that I may not hold the school, school district, or school personnel liable for any adverse reaction when the medication is administered in the prescribed manner. I hereby authorize designated school employees to assist with the appropriate medications needed by my child as stated above.

The district will incur no liability as a result of any injury arising from taking or using medications or self-monitoring devices by the student and that the parent/legal guardian will indemnify and hold harmless the district and its employees and agents against any claims arising out of the self-monitoring or self-administration of medication by the student.

The district will incur no liability as a result of any injury arising from administration of medication authorized by an IHP and that the parent/legal guardian will indemnify and hold harmless the district and its employees and agents against a claim arising from administration of medication authorized by an IHP.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Print or Type Name of Parent/Guardian Day Phone Number