Date Medication Received: _____Lot #_____ Exp Date: _____

Permission for Medication/Procedure
Kershaw County School District

Name:	**DOB:**	**Grade:**	**Teacher:**
Medication/Procedure: (one per form)		**Dosage:**	**Route:**
Purpose of Medication/Procedure:	**Frequency:**	**Allergies:**	
Possible Side Effects:	**Medical Diagnosis**:		**ICD-10**:
Is medication controlled? ☐ YES ☐ NO	**Time of day, medication/procedure to be administered at school:**		
Note any special storage requirements: ☐ Refrigerate ☐ Other: _____	**Anticipated number of days medication needs to be given at school:** ☐ Until the end of the current school year ☐ _____ weeks ☐ _____ days		

Signature of Physician:	**Date:**
Type or Print Name of Physician:	Office Phone: Office Fax:

I give permission for my child who is listed above to be given the above medication/procedure. I authorize the school nurse, the principal, or his/her designee (who may be non-nursing personnel) to assist with the medication/procedure. A record of the trainees will be kept on file by the school nurse. I understand that it is my responsibility to provide any medication and/or supplies that my child may need during school or school related activities. I give permission for the school nurse or school administrator to contact the health care provider named above, the pharmacist who filled the prescription and/or their designated employees to discuss this medication/procedure and my child's health. I give permission for the "Permission for Medication/Procedure" form to apply if I transfer my child to another school in this same school district during this same school year. I understand that the school may require that I agree to the school district rules about medications/procedures before the medicine/procedure may be given at school. Neither the school district nor its personnel will be responsible for the occurrence of any adverse drug reaction when the medication/procedure has been given/performed in the manner prescribed above. I understand that I am responsible for notifying the school if my child's medications/procedure changes in any way.

Your child may qualify for a Individualized Healthcare Plan (IHP). The school nurse will be writing this plan for your child based on medical orders. If you do not want your child to have an IHP, please contact your child's school nurse. If your child rides a bus and you would like his/her emergency medication on the bus and the bus driver trained for this medication, please contact your child's school nurse.

The school district and its employees and agents are not liable for an injury arising from administration of medication authorized by an IHP. The parent/guardian shall 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:	**Daytime Phone Number:**	**Date:**

Revised 05/15/2025