

Prescription Medication

Permission for School Administration

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

HCS NURSE USE:

ENTER ☐ IHP ☐
 UPLOAD ☐ EAP ☐
 PRINT PS ☐ SELF ☐

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 a child has never received will not be given at school.
- 3) 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.
- 4) Prescribed medications must be delivered to the school by a parent/guardian or a designated responsible adult in the original container labeled by the pharmacist, along with this completed form. The information on the prescription label must match the prescriber's order on this form. **(Do not send medication to school with a child.)** A licensed healthcare provider's order is required for:
 - All prescription medications
 - Any over-the-counter (OTC) medications used for more than 14 consecutive days
 - OTC medications used outside the manufacturer's recommendations
 - All herbal, dietary, or homeopathic supplements or remedies.

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

Student Allergies: NO ☐ YES ☐ If yes, list here: _____

The section below must be completed by the Licensed Prescriber: (This order 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 to be given at school:	Prescribed Time and Frequency to be given: (Lunch times vary from 10:30 am - 1:00 pm)
Prescribed Route medication is to be given:	List possible side effects :
Number of days medication is to be given at school: ☐ until the end of this school year OR ☐ _____ day(s)	

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

The section below must be completed by the student's Parent/Legal Guardian:

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 understand my child's health information will be shared with those who need to know for their safety and well-being.
- ♦ 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, the prescriber, the pharmacist, and/ or designee.
- ♦ 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 medication authorized by an IHP.

Signature of Parent/Guardian		Relationship to Student	Date	Phone Number
HCS USE	MEDICATION VERIFICATION	HCS NURSE 1:	DATE:	MEDICATION EXPIRATION DATE:
	MED PICK UP DISPOSAL	HCS NURSE 2:	DATE:	
		FOR NON-CONTROLLED MEDS ONLY ☐ DISPOSED OF MEDICATION PER SCDPH GUIDELINES ☐ PICKED UP BY:	DATE:	

*** HCS Med Inventory Record must accompany this form