DARLINGTON COUNTY SCHOOL DISTRICT	**Permission for School Administration of Medication** **School District: DARLINGTON COUNTY SCHOOL DISTRICT**	**School Year** _____

1. Medications should be administered by a parent or guardian before or after school hours, when possible.
2. Initial doses of a medication that a child has never taken before will not be given at school.
3. Medication to be given at school must be accompanied by this form, completed entirely. (separate form for each medication)
4. All prescribed medications must have a pharmacy label and must be in the most recent (newest) original labeled container.
5. The label and the prescriber's order on this form must match.
6. Medication must be brought to the school nurse by a responsible adult. **Students are not allowed to transport medication to or from school**.

By signing this form, the parent/guardian and health care practitioner acknowledge that information from this form may be included in the student's Individual Healthcare Plan (IHP), if applicable.

Section below must be completed by a Licensed Healthcare Provider

Student's Legal Name:		Date of Birth:
Medication:		Dosage:
Indication for Medication:		Route:
Possible Side Effects:		**ICD 10 code:**
Time medication to be given: (specify time. Lunch times vary: 10:30a – 1:30p)	Frequency: (e.g., daily)	Special storage requirements: ☐ None ☐ Refrigerate ☐ Other (please specify)
Anticipated number of days medication will be given at school: ☐ until end of current school year (includes summer programs) ☐ ____ weeks ☐ ____ days ☐ ____ overnight/extended day field trip only		ALLERGIES (food, insects, medication, etc.) Is this medication a controlled substance? □ No □ Yes

_____ _____

Prescribing Health Care Provider's Signature **Date**

Stamp, Print or Type Health Care Provider's Name & Address	Office Phone Number
	Office Fax Number

This section to be completed by child's parent or guardian:

- I give permission for my child to be given the above medication as prescribed.
- I give permission for the school nurse or school administrator to contact the health care provider named above or the pharmacist who filled the prescription to discuss this medication and my child's health.
- I give permission for the health care provider named above, the pharmacist, and/or their designated employees to provide information about this medication and my child's health to the school nurse or school administrator.
- I give permission for this form to apply if I transfer my child to another school in this same school district during the current school year.
- I agree to follow DCSD medication guidelines.
- I acknowledge that the school district and its employees and agents are not liable for any injury arising from administration of medication/treatment according to prescribed methods and/or authorized by an IHP/health care practitioner and shall indemnify and hold harmless the district and its employees and agents against a claim arising from administration of medication/treatment according to prescribed method and/or authorized by an IHP/health care practitioner.
- I agree to notify the school of changes in my child's health condition, medication and/or contact information.
- I give permission for a trained Unlicensed Assistive Personnel (UAP) to assist my child with medication in the absence of the school nurse.

_____ _____

Signature of Parent / Guardian Date

_____ _____

Print or Type Name of Parent / Guardian Day Phone Number