



Lexington County School District One Medication Permission Form

School Year: _____

Whenever possible, parents/guardians should give their students their medications before or after school hours. The school nurse should not give your student the first (initial) dose of any scheduled or routine PRN medication that he or she has never taken before. Please do that at home.

In order for your student to receive any medication, you must completely fill out one of these forms for each medication and give it to the school nurse. **A health care provider order is required for all prescription medications, all over the counter (OTC) medications that will be administered for >14 consecutive days, all OTC medications outside of the manufacturer's recommendations, and all herbal, dietary, or homeopathic supplements or remedies.** All OTC medications and herbal, dietary, or homeopathic supplements prescribed by a health care provider must have a pharmacy label and must be in its original labeled container. If you were given "samples" of medications by your health care provider, those samples must also be in a container that appropriately identifies the medication.

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.

Student's Name _____

Date of Birth _____

Name of School Student Attends _____

Grade _____

Medication:		Dose/Strength:
Indication for medication/Symptoms to treat:		ICD-10 Code:
		Route:
Time medication to be given: (Lunch times vary from 10:30 a.m.–1 p.m.)	Frequency (e.g., daily; Q8hrs):	ALLERGIES: (food, insect, medication, etc.)
Duration medication will be given at school: ☐ until end of current school year (includes summer programs) ☐ _____ weeks ☐ _____ days ☐ _____ other (please specify): _____ ☐ _____ overnight/extended day field trip only		Note special storage requirements ☐ None ☐ Refrigerate ☐ Other (please specify) Is this medication a controlled substance? ☐ No ☐ Yes
Possible side effects or activity restrictions:		
Will the student receive this medication on early release days? ☐ No ☐ Yes		

Prescribing Health Care Provider's Signature (with credentials) _____

Date _____

Stamp, Print or Type Health Care Provider's Name and Address:

Office Telephone Number

Office Fax Number

The following section is to be completed by student's parent or guardian.

I give permission for the above medication to be administered as prescribed. I give permission for the school nurse to contact the health care provider named above or the pharmacist who filled the prescription to discuss this medication. 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 student's health to the school nurse. I also give permission for this form to apply if I transfer my student to another school within the same district during the current school year. I understand the school district and its employees and agents are not liable for an injury arising from administration of medication/treatments authorized by an IHP. I agree to indemnify and hold harmless the district and its employees and agents against a claim arising from administration of medication/treatments authorized by an IHP. I agree to notify the school if my student's medication or health condition changes. I give permission for a trained unlicensed assistive personnel (UAP) to assist my student with medication in the absence of the school nurse.

Signature of Parent/Guardian _____

Date _____

Print or Type Name of Parent/Guardian _____

Day Telephone Number _____