2026-2027

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:
		HCS NURSE 2:	DATE:	
	MED PICK UP DISPOSAL	FOR NON-CONTROLLED MEDS ONLY ☐DISPOSED OF MEDICATION PER SCDPH GUIDELINES ☐PICKED UP BY:	DATE:	

*** HCS Med Inventory Record must accompany this form