Health Services Self-Medicating Authorization Form

Horry County Schools

Note that students **will not** be permitted to self-administer medications that are classified as controlled substances.

School Year 2026-2027

Student's Full Name: _____ **Date of Birth:** _____ **Grade:** _____

List Medical Diagnosis: _____

List the Medication(s): _____

Authorizations from the prescriber, the parent, and the student are required.
In each section below, please READ and INITIAL each statement indicating you agree, then sign and date. (All are required.)

HEALTH CARE PRESCRIBER
(to be completed by prescriber)

1. The student named above has been instructed regarding the appropriate use of the medication(s) noted above (i.e., indications, dosage, actions, side effects, when to take the medication, when to seek assistance). _____
2. The student has demonstrated competency for safely self-administering the medication(s) noted above. _____
3. I agree that the student should be allowed to possess and self-administer the medication(s) noted above while in any area of the school or school grounds, at any school-sponsored activity, in transit to and from school or school-sponsored activities, and during before-school or after-school activities on school-operated property. _____
4. This student does not require adult supervision to take the medication noted above. _____

_____

Prescriber's Signature **Date**

PARENT / LEGAL GUARDIAN
(to be completed by the parent/legal guardian)

1. My child has been instructed and understands the proper use of the medication(s) noted above (i.e., indications, dosage, actions, side effects, when to take the medication, when to seek assistance). _____
2. My child and I will be responsible for the proper use and safekeeping of the medication. I understand that my child must keep the medication(s) in the package provided and labeled by the pharmacy or my child's prescriber. The label must have my child's name, the medication name, dose, and directions for proper use. _____
3. I understand that my child may only self-administer the medication(s) noted above. All other medications must be given to my child by a school employee. _____
4. I understand that my child will lose the privilege to self-medicate if he or she endangers himself or herself or another student by misusing the medication(s). _____
5. I understand the school district and its employees and agents are not liable for an injury arising from my child's self-monitoring and/or self-administration of medication. _____
6. I shall indemnify and hold the district, its employees, and agents harmless against a claim arising from my child's self-monitoring and/or self-administration of medication(s). _____
7. I will be responsible for any costs related to any claims that occur related to my child self-medicating. _____
8. I authorize my child to possess and self-administer the medication(s) noted above as prescribed while in any area of the school or school grounds, at any school-sponsored activity, and during before-school or after-school activities on school property. _____
9. My child has shown me that he or she can safely self-administer the medication(s) noted above without any supervision. _____

_____

Parent/Guardian's Signature **Date**

STUDENT
(to be completed by the student)

1. I have been instructed and understand the proper use of the medication(s) noted above as directed by my prescriber (i.e., indications, dosage, actions, side effects, when to take the medication, when to seek assistance). _____
2. I understand that I must keep the medication(s) in the package provided and labeled by my pharmacy or prescriber. The label must have my name, the medication name, dose, and directions for proper use. _____
3. I will keep the medication, and any supplies needed in a safe place, and I will always have the medication with me. _____
4. I will not allow other students to touch my medication(s) or supplies. _____
5. I understand that I can only take the medication(s) noted above on my own. All other medication(s) must be given to me by a school employee. _____
6. I will no longer be able to take my medication on my own if I endanger myself or another student by misusing the medication(s). _____
7. I can safely self-administer the medication(s) noted above without any supervision. _____

_____

Student's Signature **Date**

** To be valid for the school year, this form must be signed and dated on or after July 1st*

** HCS Prescription Permission Form, Individual Health Care Plan, and Emergency Action Plan must be completed with this authorization form each school year.*

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