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|-------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| <b>Permission for School Administration of<br/>Prescription Medication</b><br><b>Richland County School District One</b><br><b>School Year:</b> _____ | For school use only:<br><input type="checkbox"/> Routine<br><input type="checkbox"/> PRN (As needed)<br><b>Start Date:</b> _____ |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|

When possible, medications should be administered by the parent/guardian before or after school hours. The first dose of any medication that your child has not taken before will not be given during school hours. Prior to your child receiving any prescribed medications during the school day, this form must be completed with the prescribing physician's signature and the signature of the parent/guardian for each medication. For the school nurse to comply with the medication order, the medication must be in its original labeled container by the pharmacy. If you receive "Sample" medications from your health care provider, the sample medications must be in a container that appropriately identifies the medication and your child.

**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 Health Care Plan, if applicable.**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of School Child Attends \_\_\_\_\_ Grade \_\_\_\_\_

**Is child allergic to any food, medicines, or other items? ☐ No ☐ Yes (List allergies.)**

|                                                                                                                                                                                                                                                                                                   |        |                                                                                                                                                                                                                                                                           |                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|
| Medication:                                                                                                                                                                                                                                                                                       |        | Medical Diagnosis:                                                                                                                                                                                                                                                        | ICD-10 Code:                           |
| Dosage:                                                                                                                                                                                                                                                                                           | Route: | Frequency: (e.g., daily)                                                                                                                                                                                                                                                  | Time medication to be given at school: |
| Anticipated number of days medication will be given at school:<br><input type="checkbox"/> until end of the current school year<br><input type="checkbox"/> _____ weeks<br><input type="checkbox"/> _____ days<br><input type="checkbox"/> until end of Summer School for the current school year |        | Special storage requirements:<br><input type="checkbox"/> None <input type="checkbox"/> Refrigerate <input type="checkbox"/> Other (please specify) _____<br><hr/> Is this medication a controlled substance?<br><input type="checkbox"/> No <input type="checkbox"/> Yes |                                        |
| Possible Side Effects:                                                                                                                                                                                                                                                                            |        |                                                                                                                                                                                                                                                                           |                                        |

\_\_\_\_\_  
Prescribing Health Care Practitioner's Signature

\_\_\_\_\_  
Date

|                                                                    |                         |
|--------------------------------------------------------------------|-------------------------|
| Stamp, Print or Type Health Care Practitioner's Name, and Address: | Office Telephone Number |
|                                                                    | Office Fax Number       |

**The following section is to be completed by the child's parent or guardian.**

I give permission for the prescribed medication noted above to be given to my child during the school day. I give permission to the school nurse or school administrator to contact the healthcare practitioner named above or the pharmacist who filled out the prescription to discuss this medication and my child's health. I give permission to the healthcare practitioner 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 the trained Unlicensed Assistive Personnel (UAP) to assist my child with medication when the school nurse is unavailable. I also give permission for this form to apply if I transfer my child to another school in Richland County School District One during the current school year and Summer School. I will not hold the school, school district, or school personnel liable for any adverse drug reactions when the medication is administered according to the prescribed method. I agree to notify the school if my child's medication changes or changes with my contact information.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print or Type Name of Parent/Guardian

\_\_\_\_\_  
Day Telephone Number