MEDICATION ADMINISTRATION PERMISSION

For Prescription and Non-Prescription Medication

POLICY JGCD-E (2)

When possible, medications should be given to students before or after school hours by the parent or guardian. Medications must be provided to the school in the originally labeled container. Medications may only be given within the limits of the prescribing health care provider's order and/or instructions printed on the container or package insert.

Please, complete a separate form for each medication to be given at school.

Student Name:		***Date of Birth:***
School:	***Grade:***	***Teacher:***

Does the student have any allergies? ☐ *Yes* ☐ *No (If yes, please list allergies.)*

This section MUST be completed by the prescribing physician/practitioner for all prescription medications, non-prescription medications given for consecutively for 14 days or more, or non-prescription medication given outside of manufacture's recommendations.

For over-the-counter, non-prescription medications given per package recommendations, the parent/guardian may complete this section.

Medication:		**Dosage:**
Purpose of Medication:	**ICD-10 Code:**	**Route:**
Time of day medication to be given at school: *(If to be given at lunch, state "lunch" since lunch times vary.)*	**Period of time medication to be given:** ☐ _____ weeks ☐ _____ days ☐ Until the end of the school year ☐ Other (please specify date) _____	
Possible side effects:		

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

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

I give permission for the medication noted above to be given to my child during the school day. I give permission for the school nurse or school administrator to contact the health care provider named above to discuss this medication and my child's health. I give permission for the health care provider named above or 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 understand that the school may require that I agree to the school district's rules about medications before this medication will be given at school. This permission will follow my child if they transfer to any other school within the School District of Pickens County. I understand that I am responsible for notifying the school if any of my child's medications change.

Signature of Parent/Guardian ***Date***

Print or Type Name of Parent/Guardian ***Day Phone Number***