AIKEN COUNTY
PUBLIC SCHOOLS

SCHOOL HEALTH SERVICES

Permission for Medication

For school use:
□ Routine
□ PRN
Start Date: _____

A parent or guardian should administer medications before or after school hours when possible. Initial doses of a medication that a child has never taken before should not be given at school. Medication to be given at school must be accompanied by this form, complete with the authorized prescriber's signature, if required. "Sample" medications must be provided in a container that appropriately identifies the medication and must be accompanied by a note signed and dated by the prescribing health care provider that includes the student's name and directions for proper administration.

By signing this form, the parent/guardian and health care provider acknowledge that information from this form may be included in the student's Individual Health Care Plan (IHP), if applicable. If all of the treatment plan or medical orders will be followed by the school as written and the IHP is consistent with the treatment plan or medical orders, the signature of the Health Care Provider and the student's parent/guardian on the IHP will not be required. The IHP will be shared with other school staff who have a legitimate need for knowledge of the information. I understand that I will receive a copy of my child's IHP if one is developed.

Student's Name	Date of Birth	Grade

Medication:	Dosage:	Route:
Purpose of Medication:		
Time of day medication will be given at school:	Frequency: (e.g. daily)	Allergies to food, medicines, or other items? ☐NO ☐YES **List allergies:**
Anticipated number of days medication will be given at school: ☐Until the end of the current school year ☐_____weeks ☐_____days		Is this medication a controlled substance? ☐NO ☐YES
Possible Side Effects:		

Health Care Provider Authorization

ICD-10 DIAGNOSIS CODE: _____

REQUIRED for Prescription, Herbal, Homeopathic, or OTC Medications with dosage outside of manufacturer's recommendations.

Prescribing Health Care Provider's Signature:	Date:
Insert Provider's Name and Address Stamp Below:	Office Phone Number: Office Fax Number:

Parent Authorization

I give permission for my child to be given the above medication as prescribed. I give permission for the school nurse or school administrator to contact the health care provider named above or the pharmacist who filled the prescription to discuss this medication and my child's health. 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 child's health to the school nurse or school administrator. I understand that the school has a written medication policy and by signing below, I agree to adhere to it. 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 methods. I will notify the school if my child's medications change.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Print or Type Name of Parent/Guardian Phone Number