ROCK HILL Schools YORK COUNTY DISTRICT THREE	**Permission for School Administration of Prescription Medication** 04/12	For school use only: ☐ Routine ☐ PRN (As needed) Start Date: _____

Medications should be administered by a parent or guardian 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 should be accompanied by this form, complete with the prescribing physician's signature, and provided to the school in the original labeled container provided by the pharmacist who filled the prescription. "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, directions for proper administration, and the name, address, and phone number of the prescribing health care provider.

_____ _____
Child's Name Date of Birth

_____ _____
Name of School Grade

Medication:		Dosage:
Medical Diagnosis/Diagnosis Code:		Route:
Time medication to be given at school (Lunch times vary (10:30a – 1p)	Frequency (e.g., daily)	Note special storage requirements ☐ None ☐ Refrigerate ☐ Other (please specify):
Anticipated number of days medication will be given at school: ☐ until end of current school year ☐ ____ weeks ☐ ____ days	Is child allergic to any food, medicines, or other items? ☐ No ☐ Yes (List allergies.)	
	Is this medication a controlled substance? ☐ No ☐ Yes	
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

Section below to be completed by child's parent or guardian:

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 also give permission for this "Permission for Prescription Medication" to apply if I transfer my child to another school in this same school district during the current school year. I understand that the school may require that I agree to the school district's rules about medications before this medicine will be given at school. I understand that I am responsible for notifying the school if my child's medications change in any way.

_____ _____
Signature of Parent / Guardian Date

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