School Term: 2022-23	Permission for School Administration of Medication Bamberg County School Empowering Every Child, Every Day	For School Use Only: ☐ Routine ☐ PRN Start Date: _____

Medications should be administered by a parent or guardian before or after school hours. 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 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 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:
Purpose of Medication:			Route:
Time of medication to be given at school (Lunch varies - 10:30a to 1p)	Frequency (e.g. daily)	Special storage requirements: ☐ None ☐ Refrigerate ☐ Other	Is this medication a controlled substance? ☐ No ☐ Yes
Anticipated number of days the medication will be given at school: ☐ Until the end of the school year ☐ _____ weeks ☐ _____days			Allergies: ☐ No ☐ Yes (list) _____ _____
Possible Side Effects:			

_____ _____

Prescribing Health Care Provider's Signature Date

Stamp, Print or Type the Health Care Provider's Name and Address:	Office Phone #: _____ Fax #:

I give permission for my child, _____, to be given the above medication as prescribed. I give permission for the school nurse or the 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 and/or the school administrator. I understand that the school requires 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 Phone number