

<h2 style="margin: 0;">School Term:</h2> <h1 style="margin: 0;">2024-25</h1>	<h3 style="margin: 0;">Permission for School Administration of Medication</h3> <p style="margin: 0;">Bamberg County School District <i>Empowering Every Child, Every Day.</i></p>	<p>For School Use Only:</p> <p><input type="checkbox"/> Routine</p> <p><input type="checkbox"/> PRN</p> <p>Start Date: _____</p>
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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: <input type="checkbox"/> None <input type="checkbox"/> Refrigerate <input type="checkbox"/> Other	Is this medication a controlled substance? <input type="checkbox"/> No <input type="checkbox"/> Yes
Anticipated number of days the medication will be given at school: <input type="checkbox"/> Until the end of the school year <input type="checkbox"/> _____ weeks <input type="checkbox"/> _____ days			Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes (list) _____ _____
Possible Side Effects:			

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

Medication Rule for 2024-25

All medication, even over-the-counter medication must be accompanied by a medical order. All medication including over-the-counter medicine must have a pharmacy label attached to the bottle/box. Bamberg County School District will NOT accept any medications without a medical order and/or without a proper prescription label.

All medication must be in the most current prescribed bottle/box and within its expiration date. The parent/guardian must bring all medication and complete all the necessary paperwork before any medication will be given.

No medication is to be sent to school by a student.