



# Non-Prescription (OTC) Medication Permission for School Administration

*This form must be completed and signed by the child's parent or legal guardian.*

Please note the following:

1. Medication must be brought to school by a responsible adult. (Do not send medication with a child.)
2. Medication should be given to students before or after school by the legal guardian, when possible.
3. Non-Prescription also known as *Over the Counter (OTC)* medications may only be given within the limits and according to the instructions printed on the container or the package insert.
4. Medication must be in the unopened, original container with manufactures label.
5. Starting doses of a medication that a child has never taken before should not be given first at school.
6. This form will apply if the child transfers to another school within HCS district.
7. HCS district may reject requests for certain medications to be given at school.

*Please complete a separate form for each medication that is to be given at school.*

*If the medication is to be given to more than one of your children, please complete a separate form for each child.*

<b>Child's Full Name:</b>		<b>Date of Birth:</b>	<b>Gender:</b> <input type="checkbox"/> Male or <input type="checkbox"/> Female
<b>Grade:</b>	<b>Homeroom Teacher:</b>	<b>Name of School:</b>	
<b>Is your child allergic to any food, medicines, or other items?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, list allergies and reactions.)			

<b>List Non-Prescription Medication:</b>	<b>Reason(s) for this Medication:</b>
<b>Dose/Amount of Medication:</b>	<b>Frequency/Time to give Medication:</b>
<b>Number of days this medication will be given at school:</b> <input type="checkbox"/> until the end of the current school year <input type="checkbox"/> _____ days <input type="checkbox"/> _____ weeks	<b>Note any special storage requirements:</b> <input type="checkbox"/> None <input type="checkbox"/> Refrigerate <input type="checkbox"/> Other: _____
<b>Does your child take any other medications at home or at school?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, list the medications?)	
<b>Child's Health Care Provider's Name and Address (print):</b>	
	<b>Office Phone:</b> _____
	<b>Office Fax:</b> _____

I agree with all of the following:

- I give permission for my child to be given the above medication as directed during the school day.
- I give consent for the HCS school nurse or designated HCS employee to contact my child's health care provider or their designee to discuss this medication and my child's health.
- I give consent for the health care provider or their designee to provide information about this medication and my child's health to the HCS school nurse or designated HCS employee.
- I further give consent for information about my child to be shared with persons who legitimately need to know for the safety and well-being of my child.
- I agree that the medication will be given per the HCS district's medication policy.
- I agree I am responsible for providing school with the medication for my child and any supplies needed.
- I agree that I am responsible for notifying the school if my child's medication(s) change in any way.

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**Parent/Guardian's Name (Print)    Signature of Parent/Guardian    Date    Daytime Phone**



# Prescription Medication Permission for School Administration

*This form must be completed by the child's prescriber and parent/legal guardian.*

Please note the following:

1. Medication must be brought to the school nurse by a responsible adult. (Do not send with a child.)
2. Medication should be administered by a parent/guardian before or after school hours, when possible.
3. All prescribed medications must be provided to the school in the original labeled container issued by the pharmacist who filled the prescription and accompanied by this form.
4. "Sample" medication must be provided in a container that appropriately identifies the medication and must be accompanied by a note signed and dated by the prescribing provider that includes the student's name and directions for proper administration, along with the permission form.
5. Starting doses of a medication that a child has never taken before should not be given first at school.
6. HCS district may reject requests for certain medications to be given at school.
7. This form will apply if the child transfers to another school within HCS district.

<b>Child's Full Name:</b>		<b>Date of Birth:</b>	<b>Gender:</b> <input type="checkbox"/> Male OR <input type="checkbox"/> Female
<b>Grade:</b>	<b>Homeroom Teacher:</b>	<b>Name of School:</b>	

**Section below must be completed by the Child's Health Care Provider:**

<b>Name of Prescribed Medication:</b>		<b>Purpose for Medication:</b>	
<b>Prescribed Dose:</b>	<b>Prescribed Route:</b>	<b>Controlled Substance:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Special Storage Required:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes _____
<b>Time of day Medication is to be given at school:</b> <small>(Please specify preferred time. "Lunch" times vary from 10:30a-1p)</small>		<b>Number of days medication will be given at school:</b> <input type="checkbox"/> until the end of the current school year <input type="checkbox"/> _____ day(s) <input type="checkbox"/> _____ week(s)	

**List possible side effects from this medication:**

**Does this child have any known allergies?**  No  Yes (If yes, list all known allergies and reactions)

**Child's Health Care Provider's Name and Office Address (print or stamp):**

**Office Phone:** \_\_\_\_\_

**Office Fax:** \_\_\_\_\_

\_\_\_\_\_  
**Health Care Provider's Signature      Date:**

**Section below must be completed by the Parent/Legal Guardian:**

**Does your child take any additional medications at home or at school?**  No  Yes (If yes, list the medications)

I agree with all of the following:

- I give permission for my child to be given the above medication as prescribed while at school.
- I give permission for the HCS school nurse or designated HCS employee to contact the prescriber, the pharmacist who filled the prescription, or their designee to discuss this medication and my child's health.
- I give permission for the health care provider, pharmacist, and/or their designee to provide information about this medication and my child's health to the HCS school nurse or administrator.
- I further give permission for information about my child to be shared with persons who legitimately need to know for the safety and well-being of my child.
- I agree to follow the HCS rules concerning medications.
- I agree that the medication will be given per the HCS district's policy.
- I agree I am responsible for providing school with the medication for my child and any supplies needed.
- I agree that I am responsible for notifying the school if my child's medication(s) change in any way.

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**Parent/Guardian's Name (Print)      Parent/Guardian's Signature      Date      Daytime Phone**