School for the Deaf and the Blind
Engage • Empower • Equip

Permission for School Administration of Prescription Medications

Health Center 864-577-7780
Fax 864-577-7629

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When possible, medications should be given to students before or after school by the parent or guardian.
Prescription medications may only be given within the limits and according to the instructions printed on the container or the package insert.
Medications must be provided to the school by the parent or guardian in the original container with current prescription label. Please note that the school district may reject requests for certain medications to be given at school.

_____ _____
*Child's Name Date of Birth

Is your child allergic to any food, medicines, or other items?
□ No
□ Yes (If yes, list allergies.)

Medication** ***(Complete one form for each medication)

*Reason for medication

Diagnosis

***ICD-10:**

*Dosage of medication to be given	*Time to be administered	*Possible side effects of medication

Special storage requirements
□ Refrigerate
□ Other (please specify)

*Termination date for medication

Does your child take any other medications at home?
□ No
□ Yes (If yes, list medications)

*Child's Health Care Provider's Name and Address (please print):

*Office Phone Number:

Office Fax Number:

***Prescribing Health Care Providers signature**_____ **Date**_____

I give permission for the medication noted above to be given to my child during the school day if needed. I give permission for the school nurse or school administrator to contact the health care provider named above to discuss this medication and my child's health. I give permission for the health care provider named above or his/her 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 may require that I agree to the school district's rules about medications before this medicine will be given at school. 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 instructions on the label or package insert. **I understand that I am responsible for notifying the school if any of my child's medications change and/or if my child's health status changes.**

* _____ * _____
Signature of Parent / Guardian Date

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

***All areas with asterisks must be completed.**