Ascent Classical Academies South Carolina

Permission for School Administration of Medication

HEALTH CARE PROVIDER AUTHORIZATION

(this section must be completed by the prescribing health care provider)

Child's Name _____ Date of Birth _____

Medication _____

Purpose of Medication _____

Dosage _____ Route _____

Frequency of Administration (e.g., daily at lunch time) _____

Is this Medication a Controlled Substance? _____ Start Date _____

Possible Side Effects _____

_____ _____

HEALTH CARE PROVIDER SIGNATURE **DATE**

Stamp, Print, or Type Health Care Provider's Name and Address	Office Phone Number

PARENT/GUARDIAN AUTHORIZATION

I give permission for my child, _____ to be given the above medication as prescribed. 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 prescribed methods.

Prescription medications must come in a container labeled with all of the following: (1) child's name, (2) name of the medicine, (3) time the medicine is to be given, (4) dosage, (5) date medicine is to be stopped, (6) licensed health care provider's name, (7) pharmacy name, and (8) pharmacy phone number. **Over-the-counter medications** must be labeled with the child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in the original container. The parent agrees to pick up expired or unused medication within one week of notification by staff. All medication(s) left at the school will be discarded according to the most current state regulatory recommendations for safe medication disposal.

By signing this document, I give permission for my child's health provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

_____ _____

PARENT LEGAL GUARDIAN PRINTED NAME **PARENT/LEGAL GUARDIAN SIGNATURE**

_____ _____

DATE PHONE NUMBER

_____ _____

ACA HEALTH CARE REPRESENTATIVE SIGNATURE DATE