CLOVER SCHOOL DISTRICT

PERMISSION FOR SCHOOL ADMINISTRATION
OF PRESCRIPTION MEDICATION

For School Use Only:
( ) Routine
( ) PRN
Start date:_____
Teacher:_____

When possible, medications should be given to students before or after school by the parent/guardian to observe for adverse side effects. Medications to be administered at school should come with this form completed and should be provided and transported to and from school by the parent/guardian in the original container. Please note that the school district retains the discretion to reject requests for certain medications to be given at school. Please complete a separate form for each medication to be given at school. If the medication is to be given to more than one of your children, please complete a separate form.

Student's Name_____ Date of Birth _____ Grade_____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Name of Medication:	**Allergies:**
Specific Reason for medication:	Check one: ( ) # of days to administer_____ ( ) Until end of school year
Amount/Dose of medication to be given:	Time of day medication to be given at school:
The student is both capable and reasonable for self-administering this medication: ( ) NO ( ) YES	The student may carry this medication: (if district policy allows) ( ) NO ( ) YES
Health Care Provider's Name and Address (Please Print):	Office Phone number: Office Fax number:
Health Care Provider's Signature (No Stamp):	Date:

TO BE COMPLETED BY PARENT

I give permission for my child, _____ to receive above stated medication as prescribed. I give permission for the school nurse or designated school official 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 designated school official. I understand that I am responsible for notifying the school if any of my child's medication changes.
I release Clover School District, its employees or agents from any claims or suits related to administration of the medication as prescribed.

Parent Signature: _____ Date: _____