Spartanburg School District SEVEN

Permission for School Administration of Non-Prescription Medication

Non-prescription medications are medicines that you can buy without a written prescription from a health care practitioner (ex. eye drops). Non-prescription medications are sometimes called "over-the-counter" medicines.

In order for a child to be given non-prescription medicines at school, the child's parent/guardian must sign a permission form. Parents or guardians will need to sign additional forms for medication that is not provided by the school. A permission form for non-prescription medicines is provided on the next page.

A responsible adult should deliver both the medicine and permission form to the school nurse. The medicine must be in the original container with the proper label on it.

Spartanburg SEVEN	**Permission for School Administration of Non-Prescription Medication**	For school use only: □ Routine □ PRN (As needed) Start Date: _____

When possible, medications should be given to students before or after school by the parent or guardian. Over the counter 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. Please note that the school district may 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 for each child.

Child's Name _____ Date of Birth _____

Name of School _____ Grade _____

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

Name of medication to be given at school:		
Reason for medication:		
Amount of medication to be given:	Time of day medication to be given at school:	How often can medication be given?
Note any special storage requirements: □ Refrigerate □ Other (please specify)	Estimated number of days medication will be given at school (choose one): □ _____ days □ _____ weeks □ until the end of the current school year	
Does your child take any other medications at home or at school? □ No □ Yes (If yes, what are the medications?)		

Child's Health Care Provider's Name and Address (please print):	Office Phone Number:
	Office Fax Number:

I give permission for the medication noted above to be given to my child during the school day. 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 _____