	Permission for Administration of Medication School/Field Trip Sumter School District	For school use only: ☐ Routine ☐ PRN (As needed) Start Date: __________

Medications should be administered by a parent or guardian before or after school hours, when possible. Initial doses of a medication that a child has never taken before should not be given at school. Medication to be given at school must be accompanied by this form, complete with the prescribing physician's signature, and provided to the school in the original labeled container provided by the pharmacist who filled the prescription.

Student's Name: ______________________________ Date of Birth: ______________________________
School Name: ________________________________ Grade/Teacher: _____________________________

Known allergies to food/medications/other: ____

Medication: _________________________________ Dosage: ______________________________
Route: ________________ Time of administration: _________________ Frequency: __________
Diagnosis/Purpose of medication: _______________________________ ICD code: ___________
Side effects/activity restrictions: ____
____
Number of days to be given: ☐ until end of school year ☐_____ weeks ☐ _____ days
Is this medication a controlled substance? ☐yes ☐no
Special storage requirements? ____

Health Care Provider: Please indicate if the student is able to self-carry the medication at school by verifying the following conditions:	
This student is both capable and responsible for self-administering this medication.	____yes ___no
This student has demonstrated competency with the involved procedure.	____yes ___no
This student may carry this medication.	____yes ___no

____ ______________________
Prescribing Healthcare Provider's Signature Date

____________________________________ ___________________ ___________________
Office Name/address Office phone # Office fax #

Section below to be read and completed by parent or guardian

I give permission for my child, ____, to be given the above medication as prescribed. I give permission for the school nurse or school administrator to contact the health care provider named above or the pharmacist who filled the prescription to discuss this medication and my child's health. I give permission for the health care provider named above, the pharmacist, and/or their designated employees to provide information about this medication and my child's health to the school nurse or school administrator. I also give permission for this "Permission for Prescription Medication" to apply if I transfer my child to another school in this same school district during the current school year. 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 understand that I am responsible for notifying the school if my child's medications change in any way.

I understand that Sumter County School District and its employees and agents are not liable for an injury arising from a student's self-monitoring and/or self-administering medications. I take full responsibility for my child's use (appropriate or inappropriate) of the medication / monitoring device while carrying the aforesaid throughout the school day, or at after school activities.

I understand that it is my responsibility to furnish the medication in a container appropriately labeled by the pharmacy or physician. I acknowledge that all medication must be brought to school by a responsible adult and never sent to school with the child.

If the physician has verified that the student is able and responsible to self-carry the medication at school, I agree that this is appropriate for my child. ☐ **yes** ☐ **no**

______________________________ ______________________________ ____________________
Signature of Parent/Guardian **Date** **Daytime phone #**