Form A	**Permission for Prescription Medication Administration** **Heathwood Hall School**	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. Prescription medication to be given at school should 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. "Sample" medications must be provided in a container that appropriately identifies the medication and must be accompanied by a note signed and dated by the prescribing health care provider that includes the student's name, directions for proper administration, and the name, address, and phone number of the prescribing health care provider. **All medications must be current; expired medications will not be administered.**

_____ _____
Child's Name Date of Birth

_____ _____
Name of School Grade

Medication:	Dosage:
Purpose of Medication:	Route of Administration:
Time of day medication to be given at school: If possible, please specify preferred time. Lunch times vary (10:30a – 1p).	Note any special storage requirements: ☐ None ☐ Refrigerate ☐ Other (please specify):
Anticipated number of days medication will be given at school: ☐ until end of current school year ☐ ____ weeks ☐ ____ days	Is child allergic to any food, medicines, or other items? ☐ No ☐ Yes (List allergies.) Is this medication a controlled substance? ☐ No ☐ Yes
Possible Side Effects:	

_____ _____
Prescribing Health Care Provider's Signature Date

Stamp, Print or Type Health Care Provider's Name & Address:	
	Office Phone Number
	Office Fax Number

Section below to be completed by child's parent or guardian:

I give permission for my child, _____, to be given the medication noted above as prescribed 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, and/or their designated employees to provide information about this medication and my child's health to the school nurse or school administrator. I understand that I am responsible for notifying the school of any change of medication or dose. I will not hold Heathwood Hall Episcopal School and/or its employees and agents liable for any adverse reactions experienced by my child.

_____ _____
Signature of Parent / Guardian Date

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

Heathwood Hall Fax Number: 803.748.4755 **Heathwood Hall Health Office: 803.231.7728**