# Prescription Medication

## Permission for School Administration

(This form must be completed by the child's prescriber and parent/guardian)

Please note the following requirements:

1. Medication must be brought to the school nurse by a responsible adult. (Do not send with a child)
2. Medication should be administered by a parent/guardian before or after school hours, when possible.
3. All prescribed medications must be provided to the school in the original labeled container issued by the pharmacist and accompanied by this permission form. (The label and the prescriber's order on this form must match)
4. Any prescribed controlled substance must be brought to the school nurse by the parent when the prescription is filled each month and must be provided to the school nurse in the most recent pharmacy-labeled container.
5. "Sample" medication must be provided in a container appropriately labeled, which identifies the medication, and must be accompanied by a note signed and dated by the prescribing provider that includes the student's name and directions for proper administration along with this permission form.
6. The first dose of a medication that a child has never received will not be given at school.
7. Christian Academy of Myrtle Beach (CAMB) may reject requests for certain medications to be given at school
8. Herbal substances are not considered medication and will not be administered by the school nurse

Child's Full Name: _____ Date of Birth: _____

Gender: ☐ Male or ☐ Female Grade Level/Teacher:_____

| ***This section must be completed by the Child's Prescribing Health Care Provider*** | | |
|---|---|---|
| Name of **Prescription Medication** to be given at school: | | **Reason(s)** for this medication to be given at school: |
| Prescribed **Dose/Strength**: | **Amount** to be given at school: | **Frequency/Time** to be given at school:<br>(Please specify preferred time. "Lunch" times vary) |
| **Prescribed Route**: | **Controlled Substance**:<br>☐ No ☐ Yes | **Number of days medication** is to be given at school:<br>☐ until the end of the current school year ☐ _____ days |
| **Special Storage Required:**<br>☐ No ☐ Yes _____ | **List possible side effects** from this medication: | |
| Prescribing Health Care Provider's Name & Office: (please print or stamp):<br><br>Office Phone / Fax: _____<br><br>Signature of Prescriber: _____ Date: _____<br><br>**Please note: this form is only valid if signed on or after July 1 for the upcoming school year. | | |

| ***This section must be completed by the Child's Parent/Legal Guardian*** |
|---|
| **Does this child have any known allergies?**: ☐ No ☐ Yes<br>If yes, list all known allergies and type of reaction(s): |
| **Does this child take any additional medications at home or at school?** ☐ No ☐ Yes<br>If yes, list the medication(s) taken at home: |

By signing below, I understand and agree to the following:

- I give permission for my child to be given the above medication as prescribed while at school.
- I give permission for information about this medication and/or my child's health to be exchanged between the CAMB nurse or designated employee and/or the Health Care Provider, the prescriber, the pharmacist who filled this prescription and/or their designee.
- I further give permission for information about my child to be shared with persons who legitimately need to know for the safety and well being of my child.
- I aree to follow the CAMB policies concerning medication and that medication will be given per the school's policies.
- I agree I am responsible for providing the school with the medication for my child and any supplies needed
- I agree that I am responsible for notifying the school if my child's health and/or medication(s) change in any way.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Signature of Parent/Legal Guardian | Today's Date | Phone Number | Relationship to Student |

CAMB Med Review by: _____ Date: _____