



Non-Prescription (OTC) Medication Permission for School Administration
 This form must be completed and signed by the child's parent or legal guardian.

Please note the following:

1. Medication must be brought to school by a responsible adult. (Do not send medication with a child.)
2. Medication should be given to students before or after school when possible.
3. Non-prescription also known as Over the Counter (OTC) medications may only be given within the limits and according to the instructions printed on the container or package insert.
4. Medication must be in the unopened, original container with manufactures label.
5. Starting doses of a medication that a child has never taken before should not be given first at school.
6. HTCS may reject requests for certain medications to be given at school

Please complete a separate form for each medication that is 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.

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|---|-------------------|
| Child's Full Name: | Date of Birth: |
| Grade: | Homeroom Teacher: |
| Is your child allergic to any food, medicines, or other items? No <input type="checkbox"/> Yes <input type="checkbox"/> | Allergies |
| *If yes, list allergies and reactions in Allergy column.* | |

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| List Non-Prescription Medication: | Reason(s) for this Medication: |
| Dose/Amount of Medication: | Frequency/Time to give Medication: |
| Number of days this medication will be given at school: <input type="checkbox"/> Until the end of the current school year _____ days _____ weeks | Note any special storage requirements: <input type="checkbox"/> None <input type="checkbox"/> Refrigerate <input type="checkbox"/> Other _____ |
| Does your child take any other medication(s) at home or school? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, list the medications in the Medication column) | Medications: |
| Child's Health Care Provider's Name and Address: | Office phone: Office fax: |

I agree with all of the following:

- I give permission for my child to be given the above medication as directed during the school day.
- I give consent for the school nurse or other designated HTCS employee to contact my child's health care provider or their designee to discuss this medication and my child's health.
- I give consent for the health care provider or their designee to provide information about this medication and my child's health to the HTCS school nurse or designated employee.
- I further give consent 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 agree that the medication will be given per the Diocese of Charleston's medication policy.
- I agree I am responsible for providing the medication for my child and any supplies needed to the school.
- I agree that I am responsible for notifying the school if my child's medication(s) change in any way.

Parent/Guardian's Name (Print) _____

Signature of Parent/Guardian Date _____

Daytime Phone _____