CLOVER SCHOOL DISTRICT
PERMISSION TO GIVE NON-PRESCRIPTION MEDICATION AT SCHOOL

Student's Name:	**DOB:**	
School:	**Grade:**	**Teacher:**

Name of Medication: _____

Reason for Medication: _____

Dosage of Medication: _____Time to be Administered: _____

Estimated number of days medication is to be given at school: (choose one)

- □ _____ Days
- □ _____ Weeks
- □ _____ until the end of school year

Medication Allergies (Please list): _____

Food Allergies (Please list):

***I understand it is my responsibility to:**	I hereby give permission for my child,
• Provide medication in original/prescribed container • Inform the school if medication is discontinued or changed • Obtain a new form if dosage of medication is changed • Bring medication to school unless student has been approved to self-medicate • Give the first dose of medication at home to observe for adverse side effects.	_____ to receive above stated medication as directed and release Clover School District, its employees or agents from any claims or suits related to administration of medications as prescribed. I give permission for the school nurse to contact the Health Care Provider to discuss my child's health or medication. The school has the discretion to reject requests for giving certain medication. I understand medication will not be sent home on the bus.

Parent Signature _____Date _____

Parent Daytime Phone Number _____

PRN Medication Administration Record

Name:	DOB:
Grade/Team:	Allergies:
Medication/Dosage:	

Date	Time	Initials	Reason

Signature	Initials	Signature	Initials

*All students are instructed to return if this medication does not relieve symptoms. May 2022