BCSD Prescription Medication

Permission for School Administration

School Year: 2025-2026

SS-46(E)1

IHP ____

EAP ____

Must be completed by the child's healthcare provider and parent/legal guardian.

Please note the following:

- Medications should be administered by a parent or legal guardian before or after school hours.
- Medications must be delivered to the school nurse by a responsible adult. (Please do not send medications with the child.)
- All prescribed medications must be provided in the original labeled container issued by the pharmacist and accompanied by this permission form. (Ensure that the label matches the healthcare provider's order on this form.)
- Any prescribed controlled substances must be brought to the school nurse by the parent or legal guardian each month when the prescription is filled and must be in the most recent pharmacy-labeled container.
- **Students are not permitted to self-carry or self-administer medications classified as controlled substances.**
- "Sample" medications must be provided in an appropriately labeled container, clearly identifying the medication, and must include a note signed and dated by the healthcare provider with the student's name and administration directions, along with this permission form.
- Herbal medications or substances are not FDA approved and will not be administered by the school nurse.
- The first doses of any medication that a child has never taken will not be given at school.
- BCSD reserves the right to deny requests for certain medications to be administered at school.
- This form remains valid if the child transfers to another school within BCSD during the current school year.
- A separate form must be completed for each medication to be administered at school.

Child's Full Name: _____ **Grade Level:** _____ **Date of Birth:**_____ **Gender: Male ☐ Female ☐**

Section below must be completed and signed by the child's HEALTHCARE PROVIDER:

Name of **Prescription Medication** to be given at school**:**		**Reason(s)** for this Medication to be given at school**:**
Prescribed **Dose/Strength:** (i.e. 50 mg, mcg, grams)	**Amount** to be given at School**:** (i.e., 1 tab, 5 ml, 0.5 tab, 2 puffs)	**Frequency or Time** to be given at school**:** (For time, please specify preferred time. "Lunch" times vary from 10:30a-1p)
Prescribed **Route**:	**Controlled Substance:** ☐ No ☐ Yes	**Number of days medication** is to be given at school**:** ☐ until the end of the current school year ☐_____day(s)
List **possible side effects** from this medication**:**		**Special Storage Required:** ☐ No ☐ Yes _____

Student has permission to self-carry /self-administer this medication for (Emergency Medications Only): No ☐ Yes ☐– if yes, read the following carefully:

If yes box is checked, I agree that this student must be allowed to have the above-named medication/procedure on his/her person during school hours, in transit to and from school or school-sponsored activities, before and after-school activities on school property, and any school sponsored activity. **This child has demonstrated competency in self-monitoring and self-administration of this medication/procedure.** The parent is aware that they cannot hold the school district responsible for any adverse outcome of this action.

_____ _____ _____

Provider's Name & Office:** (please print or stamp) Office Phone Fax

_____ _____

Signature of Healthcare Provider Date

Section Below Must Be Completed and Signed by Parent/Legal Guardian

**Does this student have any known allergies? ☐ No ☐ Yes (If yes, list all known allergies and type of reaction):_____

**Does this Child take any additional medications at home or school? ☐ No ☐ Yes (If yes, list the medications taken at home or school):_____

Parents~~–~~Legal.Guardians.Please.Read.Carefully¿By.signing.below?I.understand.and.agree.to.the.following¿

- An Individualized Healthcare Plan (IHP) will be developed for students with health conditions requiring one.
- The school district and its employees and agents are not liable for injuries arising from a student's self-monitoring or self-administration of medication.
- The parent or guardian indemnifies and holds harmless the district and its employees and agents against claims arising from a student's self-monitoring or self-administration of medication.
- The school district and its employees and agents are not liable for injuries arising from medication administration authorized by an IHP.
- The parent or guardian shall indemnify and hold harmless the district and its employees and agents against claims arising from administration of medication authorized by an IHP.
- I give permission for my child to receive the above medication as prescribed while at school, in accordance with BCSD policies.
- I authorize the exchange of information regarding this medication and/or my child's health between the BCSD school nurse or designated BCSD employee and/or the healthcare provider, the pharmacist who filled this prescription, and/or their designee.
- I further grant permission for my child's information to be shared with individuals who legitimately need to know for their safety and well-being.
- I agree to allow my child's medication to accompany the teacher/staff on field trips if medication time coincides with the trip.
- I agree to adhere to BCSD policies regarding medications.
- I acknowledge that it is my responsibility to provide the school with my child's medication and any necessary supplies.
- I understand it is my responsibility to notify the school of any changes in my child's health or medications.

_____ _____ _____ _____

Parent/Guardian's Signature **Parent/Guardian's Name (Print)** **Date** **Phone Number**