Coastal High School
2100 River Oaks Dr.
Myrtle Beach, SC 29579
843-788-9898 FAX 888-410-4826

Prescription Medication Permission for School Administration

This form must be completed by the child's prescriber and parent/legal guardian.

Student's Name (Last, First, Middle)	Date of Birth:	Grade:

Section below must be completed by Student's Health Care Provider:

Name of Prescribed Medication:		Purpose of Medication:	
Prescribed Dose:	**Prescribed Route:**	**Controlled Substance:** ☐ No ☐ Yes	**Special Storage Required:** ☐ None ☐ Refrigerate ☐ Other: _____
Time of day Medication is to be given at school: (Please specify preferred time.)		**Number of days medication will be given at school:** ☐ Until the end of the school year ☐ _____ day(s) ☐ _____ week(s)	

List possible side effects from this medication:

Does this student have any known allergies? ☐ No ☐ Yes (If yes, list all known allergies and reactions)

Student's Health Care Provider's Name and office Address (print or stamp):	Office Phone:
_____ _____	Office Fax:
Health Care Provider's Signature **Date**	_____

Section below must be completed by the Parent/Legal Guardian:

Does your child take any additional medications or supplements at home or at school? ☐ **No** ☐ **Yes (If yes, list the medications :**

_____

I agree with all of the following:

- I give permission for my child to be given the above medication as prescribed while at school.
- I give permission for the designated Coastal High School employee to contact the prescriber, the pharmacist who filled the prescription, or their designee to discuss this medication and my child's health.
- I give permission for the health care provider, pharmacist, and/or their designee to provide information about this medication and my child's health to Coastal High School's designated employee or administrator.
- I 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 agree to follow Coastal High School's rules concerning medications.
- I agree that the medication will be given per the school's policy.
- 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 medication(s) change in any way.
- I agree that I am responsible for picking up unused medication during school breaks and at the end of the student's enrollment.

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