Williston-Elko School District
Permission for Medication

12255 Main Street | Williston, SC 29853 | (803) 266-7878

Circle: KEES - WEMS - WEHS

For school use:

□ Routine

□ PRN

Start Date:_____

Medications should be given to the student before or after school by the parent/guardian when possible. Medication to be given at school must be brought to the school in the original container accompanied by this completed form. Prescription medications require the healthcare provider's signature below. Medications may only be given within the limits and directions printed on the package. "Sample" medications must be provided in a container that appropriately identifies the medication and must be accompanied by a note signed and dated by the prescribing healthcare provider that includes the student's name and directions for administration.

The school district may reject requests for certain medications 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.

Student's Name	Date of Birth	Grade

Medication:	Dosage:	Route:
Purpose of Medication:		Expiration Date:
Time of day medication will be given at school:	Frequency: (e.g.daily)	Allergies to food, medicines, or other items? ☐NO ☐YES **List allergies:**
Anticipated number of days medication will be given at school: ☐ Until the end of the current school year ☐ _____weeks ☐ _____days		Is this medication a controlled substance? ☐NO ☐YES
Possible Side Effects:		

Healthcare Provider Authorization

Prescribing Healthcare Provider's Signature:(Required if Prescribed Medication)	Date:
Insert Provider's Name and Address Stamp Below:	Office Phone Number: Office Fax Number:

Parent Authorization

I give permission for my child to be given the above medication as prescribed. I give permission for the school nurse or school administrator to contact the healthcare provider named above or the pharmacist who filled the prescription to discuss this medication and my child's health. I give permission for the healthcare provider named above, the pharmacist, and/or their designated employees to provide information about this medication and my child's health to the school nurse or school administrator. I understand that the school has a written medication policy and, by signing below, I agree to adhere to it. I understand that when the school nurse is not present that non-nursing school personnel will assist my child with this medication. I will not hold the school, school district, or school personnel liable for any adverse drug reactions when the medication is administered according to the prescribed methods. I will notify the school if my child's medication or health status changes.

Signature of Parent/Guardian	Date
Print Name of Parent/Guardian	Phone Number

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