

REQUEST FOR *PRESCRIPTION* MEDICATION ADMINISTRATION AT SCHOOL 2026-2027 School Year

University School of the Lowcountry requires that parents of a student needing prescription medication during school hours present the following:

1. A medication administration form signed by a parent and the prescribing physician.
2. Medication in the original prescription bottle properly labeled by a registered pharmacist as prescribed by law. The student's name and the physician's name must be on the label. **NO OTHER CONTAINERS WILL BE ACCEPTED.**

Renewed prescriptions must be sent to school in the prescription bottle as issued by the pharmacist.

A parent, **NOT THE STUDENT**, must deliver and pick up medicines and inform the school of any changes in medication, dosage, student conditions or restrictions.

Name of Student: _____ Grade: _____

Medication: _____ Prescribing Physician: _____

Dosage: _____

Time of day to be given at school: _____

Number of day to be given at school: _____

Purpose of medication: _____

Possible side effects: _____

Student restrictions, if any, and length of time: _____

I hereby give permission for _____ to take the above medication at school. I will not hold University School of the Lowcountry or the school nurse (or person designated by the head of school) liable for any adverse reaction experienced by the student.

Signature of Parent: _____ Date: _____

Signature of Physician: _____ Date: _____