2026-2027

MBSA

Myrtle Beach STEM Academy

(OTC) Non-Prescription Medication

Permission for School Administration

(This form must be completed by the student's Parent/Guardian.)

MBSA NURSE USE:

☐ ENTER ☐ IHP
☐ UPLOAD ☐ EAP
☐ PRINT PS

Please note:

1) **The parent/guardian is responsible for administering morning and/or after-school doses** of medication(s) unless there is a special circumstance. Special circumstances must be discussed with the MBSA nurse before implementation.
2) **MBSA may reject requests for certain medication(s) to be given at school. The first dose of a new medication** that a child has never received will not be given at school. Herbal and dietary supplements will only be administered if ordered by a licensed healthcare provider and provided in a pharmacy labeled container.
3) **Non-Prescription, also known as Over the Counter (OTC) medications may only be given within the limits and** according to the manufacturer's instructions. If the OTC medication is to be given outside of the recommended manufacturer's guidelines, a Physician's order will be required and then it is considered a prescription medication.
4) **Over the Counter (OTC) medications must be delivered to the school by the parent/guardian or responsible adult** designee in the unopened, original container with the label from manufacturer. (Bring a small unopened bottle.) Do not send medication in with a child.

Student's Name: _____ **Birthdate:** _____ **Grade:** _

Student Allergies: NO: ☐ YES: ☐ If yes, list here: _____

This must be completed by the student's Parent/Legal Guardian:

Name of Non-Prescription Medication to be given:	**Reason(s) for this medication to be given at school:**
Dose / Amount to be given at school: *(must be within the limits of the manufacturer's instructions)*	**Frequency to be given at school:** *(must be within the limits of the manufacturer's instructions)*

Number of days medication is to be given at school: ☐ until the end of this school year **OR** ☐ _____ day(s)

By signing below, I understand and agree to the following:

- I request and agree for my child to be given the above medication while at school.
- I am responsible for providing the school with the medication and any required supplies for my child.
- I agree to follow MBSA policies concerning medications.
- I agree for information about this medication and/or my child's health to be exchanged between the MBSA nurse or designated MBSA employee and/or my child's Health Care Provider or designated personnel.
- I agree for information about my child to be shared with those who need to know for their safety and well-being.
- I understand it is my responsibility to notify the school if my child's health and/or medication(s) change in any way.
- MBSA and its employees and agents are not liable for any injury arising from the administration of authorized medication.
- The parent/guardian shall indemnify and hold harmless MBSA and its employees and agents against a claim arising from administration of medication authorized by an IHP.

Signature of Parent/Guardian	***Relationship to Student***	***Date***	***Phone Number***

** To be valid for the school year this form must be signed and dated on or after July 1st*

MBSA NURSE USE			
	MEDICATION VERIFICATION	MBSA NURSE:_____ DATE:____	**MEDICATION EXPIRATION DATE:**
	MEDICATION PICK UP / DISPOSAL	☐ DISPOSED OF MEDICATION PER SCDPH GUIDELINES. ☐ PICKED UP BY: _____	DATE:

Rev 4/2026