MED-1 rev 2010

THE SCHOOL DISTRICT OF GREENVILLE COUNTY

AUTHORIZATION FOR PRESCRIPTION MEDICATION AT SCHOOL

(MUST BE SIGNED BY PARENT AND PHYSICIAN)

PLEASE PRINT *SCHOOL YEAR:* ______________________

STUDENT'S NAME: ___________________________________ BIRTH DATE: ______________

LEGAL GUARDIAN: __________________________________ DAYTIME PHONE: __________________

NAME OF MEDICATION: ____

REASON FOR GIVEN MEDICATION AT SCHOOL. (PLEASE BE SPECIFIC):

____

AMOUNT OF MEDICATION TO BE GIVEN: _______________________

TIME OF DAY MEDICATION IS TO BE GIVEN AT SCHOOL: _________________________________

EXPIRATION DATE OF MEDICATION: _______________________________________

DATE TO ***START*** MEDICATION: __________________

DATE TO ***STOP*** MEDICATION: _________________

POSSIBLE SIDE EFFECTS: ____

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PHYSICIAN SIGNATURE: _______________________________________ DATE: ________________

OFFICE PHONE #: ___________________________________

PARENTS PLEASE READ CAREFULLY:

I understand that all medication will be provided by me in the original container, clearly labeled with my child's name. *I will notify the school if the medication is discontinued or the dosage has been changed.* Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions. I give the school nurse my permission to contact the above named Physician's office to request medical information concerning my child. I am responsible for replacing medication before the expiration date.

LEGAL GUARDIAN'S SIGNATURE: ___________________________________ DATE: ________________