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: _____

_____

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: _____