

## THE SCHOOL DISTRICT OF GREENVILLE COUNTY AUTHORIZATION FOR PRESCRIPTION MEDICATION AT SCHOOL

(MUST BE SIGNED BY PARENT AND PHYSICIAN)

<u>PLEASE PRINT</u>	SCHOOL YEAR:
STUDENT'S NAME:	
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 <b>START</b> MEDICATION:	
DATE TO <i>STOP</i> MEDICATION:	
POSSIBLE SIDE EFFECTS:	
PHYSICIAN SIGNATURE:	
OFFICE PHONE #:	
PARENTS PLEASE READ CAREFULLY:	
I understand that all medication will be provided by me in child's name. <i>I will notify the school if the medication is di</i> Permission is granted to the principal and/or school nurse to sharesponsibility for my child. The first dose will be given at home the school nurse my permission to contact the above named Phyconcerning my child. I am responsible for replacing medication by the concerning my child. I am responsible for replacing medication by the concerning my child.	iscontinued or the dosage has been changed. are this information with individuals who have so that I can monitor adverse reactions. I give ysician's office to request medical information before the expiration date.
LEGAL GUARDIAN'S SIGNATURE:	DATE: