GREENVILLE COUNTY SCHOOLS
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Greenville County School District Health Services

AUTHORIZATION FOR PRESCRIPTION MEDICATION AT SCHOOL

- *Please complete a separate form for each medication.*
- *Medication must be brought to the school nurse by a responsible adult. (Do not send medication with a student).*
- *Medication should routinely be given at home before or after school, whenever possible.*
- *All prescribed medications must be in the original container issued by the pharmacist with the most recent prescription label.*
- *If the information on the authorization form does not match the prescription label, the medication will not be accepted.*
- *Herbal/alternative medicinal products and narcotic medications will not be administered in the school setting.*
- *Medications will not be administered without this completed form including required signatures.*

THIS SECTION MUST BE FILLED OUT BY A LICENSED HEALTH CARE PROVIDER ONLY - PLEASE PRINT		
Student's Legal Name:		Date of Birth:
List Allergies :		
Name of Prescribed Medication:	Purpose of Medication at School:	
Prescribed Dose:	Prescribed Time of day for administration at school: (specific time i.e. 8:00am, "after breakfast", or "lunchtime")	Prescribed Route:
Date to Start Medication:	Date to Stop Medication:	
Possible Side Effects:		
Licensed Health Care Provider Name : (Print info or stamp is acceptable) Office Address:		Phone: Fax:
Licensed Health Care Provider's Signature:		Date:

PARENTS/LEGAL GUARDIANS PLEASE READ CAREFULLY:
By signing below, I understand and agree to the following:

- I understand that all prescribed medications must be in the original container issued by the pharmacist with the most recent prescription label.
- I will notify the school when the medication is discontinued or the dosage has been changed.
- I give permission for the principal, school nurse(s), and/or health services to share this information with individuals who have responsibility for my child.
- The first dose of any new medication will be given at home so that I can monitor for adverse reactions.
- I give GCSD Health Services my permission to contact the above named Licensed Health Care Provider and prescribing pharmacy in relation to this prescription medication.
- I am responsible for replacing medication before the expiration date.
- I give my permission for designated GSCD staff to administer this medication to my child according to district requirements.

Parent/Legal Guardian's Signature _____ Date: _____

Parent/Legal Guardian Printed Name: _____ Phone Number: _____