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 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 Prescription Medication to be given at school:	**Purpose** of Medication at School:	
Prescribed Dose: (i.e. 5mg, 10mg, etc.)	**For Liquid Medication Only:** **Concentration =** _____mg/_____ml **Dose** = _____ ml	
Prescribed Time of Day for administration at school: (specific time i.e. 8:00am, "after breakfast", or "lunchtime")	**Prescribed Route**: (i.e. oral, inhaled, rectal, etc.)	**Special Instructions**: (i.e. crush, give with applesauce)
Date to Start Medication:	**Date to Stop** Medication:	
List 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 GCSD staff to administer this medication to my child according to district requirements.

Parent/Legal Guardian's Signature _____ Date: _____

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

This form is only valid if signed on or after July 1st for the upcoming school year.