MED-2 rev 2010

*THE SCHOOL DISTRICT OF GREENVILLE COUNTY*

# AUTHORIZATION FOR SELF-ADMINISTRATION OF 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 TAKING MEDICATION AT SCHOOL. (PLEASE BE SPECIFIC):

_____

AMOUNT OF MEDICATION TO BE TAKEN: _____

TIME MEDICATION IS TO BE TAKEN AT SCHOOL: _____

DATE TO ***START*** MEDICATION: _____ DATE TO ***STOP*** MEDICATION: _____

EXPIRATION DATE OF MEDICATION: _____ POSSIBLE SIDE EFFECTS: _____

***Parent's please read carefully:***

Working closely with our Physician we have decided to allow my child to self-administer and self-monitor the above medication while at school. My child has been trained by our physician and has demonstrated competency in this procedure. My child must be allowed to possess this medication at school sponsored activities, in transit to and from school or school-sponsored activities, and during before or after-school activities on school property. I realize that the School District of Greenville County can not be held responsible for any adverse outcome of this action. I am responsible for replacing expired medication before the expiration date. I will provide the medication in the original container, clearly labeled with my child's name. I will notify the school immediately 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 physician's office to request medical information concerning my child.

Legal Guardian's Signature: _____ Date: _____

***Physician please read carefully:***

I agree that this student must be allowed to have the above named medication on his/her person during school hours, in transit to and from school or school-sponsored activities, before and after-school activities on school property, and any school sponsored activity. This child has demonstrated competency in self-monitoring and self-administration of this medication. The parent is aware that they can not hold the school district responsible for any adverse outcome of this action.

Physician Signature: _____ Date: _____

Office phone #: _____ School Designee: _____