

This section must be completed by Licensed Medical Provider only: Please Print		
Student Name:	Date of Birth:	
List Allergies :		
Prescribed epinephrine type: ☐ Auto-Injector ☐ Nasal Spray	Prescribed Auto-injector Dose: ☐ 0.15 mg ☐ 0.3 mg Prescribed Nasal Spray Dose: ☐ 1 mg ☐ 2 mg	Prescribed Route: ☐ Intramuscular ☐ Intranasal
Prescribed antihistamine:	Prescribed Antihistamine Dose: _____ For Liquids Concentration = _____ mg/ _____ ml Dose = _____ ml	Prescribed Route: Oral
Specific instructions for medication administration (Example: give diphenhydramine prior to epinephrine):		
Symptoms may start as: (check all that apply) ☐ Itching and swelling of the lips, tongue or mouth ☐ Hives, itchy rash, swelling around the face or extremities ☐ Thready pulse or passing out ☐ Itching and/or a sense of tightness in the throat, hoarseness and hacking cough ☐ Shortness of breath, repetitive coughing and/or wheezing ☐ Nausea, abdominal cramps, vomiting and/or diarrhea ☐ Other _____		
Bus Travel: This student must have his/her epinephrine available on the bus to and from school: ☐ Yes ☐ No		
Student has permission to Self-Carry/Self-Administer this medication: ☐ No ☐ Yes – if yes, read the following carefully: If yes box is checked, I agree that this student must be allowed to have the above-named medication/procedure 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/procedure. The parent is aware that they cannot hold the school district responsible for any adverse outcome of this action. Printed Name of Licensed Medical Provider: _____ Phone: _____ Licensed Medical Provider 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 changes. - I give permission for the principal, school nurse, health services to share this information with individuals who have responsibility for my child. - I give GCS D Health Services my permission to contact the prescribing Licensed Medical 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 GCS D staff to administer this medication to my child according to district requirements. - GCS Transportation department staff are required to complete online training for health emergencies annually. Additional training by a licensed GCS nurse will be provided as warranted. - The school district and its employees and agents are not liable for an injury arising from administration of medication authorized by an ICHP (care plan) / licensed medical provider. - The parent/guarding shall indemnify and hold harmless the district and its employees and agents against a claim arising from administration of medication authorized by an IHP (care plan) / licensed medical provider. My student has orders from our health care provider to Self-Carry/Self-Administer this medication: ☐ No ☐ Yes <i>*If yes, read the following carefully:</i> <i>*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 cannot 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 (except emergency medications). I give the school nurse my permission to contact the physician's office to request medical information concerning my child. The school district and its employees and agents are not liable for an injury arising from a student's self-monitoring or self-administration of medications. The parent/guardian shall indemnify and hold harmless the district and its employees and agents against a claim arising from a student's self-monitoring or self-administration of medication.</i> Parent/Legal Guardian Printed Name: _____ Daytime Phone Number: _____ Parent/Legal Guardian Signature: _____ Date: _____		