

Greenville County School District Health Services

AUTHORIZATION FOR NON-PRESCRIPTION/OVER THE COUNTER MEDICATION AT SCHOOL

- *A separate form for each medication must be completed.*
- *Medication must be brought to the health room by the parent or responsible adult. Do not send medication with a student.*
- *Medication should be routinely given at home before or after school, whenever possible.*
- *Medication must be provided in a new, unopened container with the manufacturer's label intact (smaller containers preferred).*
- *If the medication dose requested exceeds the manufacturer's recommendations and/or administration of medication will be greater than 10 consecutive days, a Licensed Health Care Provider must complete the Authorization for Prescription Medication at School form (MED-1). Contact your school nurse for more information.*
- *Medication will not be administered without this completed form including parent/guardian signature.*

Student's Legal Name:		Date of Birth:	
Current Weight: _____ lbs.		List Allergies:	
Name of Medication:		Purpose of Medication at School:	
Dose: example: 100mg, 250mg (dose may not exceed manufacturer's direction) _____		For Liquid Medication Only: Concentration = _____ mg/_____ ml Dose = _____ ml	
Frequency (may not exceed manufacturer's direction):		Route:	
Date to Start Medication:		Date to Stop Medication:	
List Possible Side Effects:			

PARENTS/LEGAL GUARDIANS PLEASE READ CAREFULLY:

By signing below, I understand and agree to the following:

- I understand that all medication will be provided in a new, unopened container with manufacturer's label intact and labeled with my child's name.
- 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 am responsible for replacing medication before the expiration date.
- I give my permission for the GCSD to administer this medication to my child as directed by the manufacturer, 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.