



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 Medical Provider Only – Please Print			
Student's Legal Name:	Date of Birth:	Current Weight _____ lbs.	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 Medical Provider Name: (Print info or stamp is acceptable)		Phone:	
Office Address:		Fax:	
Licensed Medical 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 GCSH Health Services my permission to contact the above-named 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 GCSH staff to administer this medication to my child according to district requirements.
- 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/guardian 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.

Parent/Legal Guardian's Signature _____ Date: _____

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

**This document should be dated on or after June 1st for the upcoming school year. **