MED-1

THE SCHOOL DISTRICT OF GREENVILLE COUNTY

PARENTAL PERMISSION FOR MEDICATION AT SCHOOL

**** PHYSICIAN'S AUTHORIZATION MUST BE PROVIDED IF GIVEN MORE THAN 10 CONSECUTIVE SCHOOL DAYS ****

STUDENT'S NAME: ______________________ BIRTH DATE: __________

PARENT/GUARDIAN: ______________________

HOME PHONE: ______________ WORK PHONE: ______________

NAME OF MEDICATION: ______________________

CONDITION FOR WHICH MEDICATION IS TO BE GIVEN: ______________

AMOUNT OF MEDICATION TO BE GIVEN: ______________

MEDICATION IS TO BE GIVEN: _____ AS NEEDED **OR** _____ EVERY DAY

[ ] FOR A SHORT TIME ONLY
FROM __________ (DATE) **TO** __________ (DATE)

TIME OF DAY TO BE GIVEN: __________

PRESCRIBED BY: ______________________ PHONE: __________

POSSIBLE SIDE EFFECTS: ______________________

I understand that all medication will be provided by me in the original container. ***I will notify the the school if the medication is discontinued or the dosage has been changed***. Permission is granted to 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 above named Physician's office to request medical information concerning my child.

______________________________ __________
PARENT'S SIGNATURE **DATE**

PLEASE NOTE:

ANY MEDICATION NOT PICKED UP BY THE LAST DAY OF SCHOOL WILL BE DESTROYED ACCORDING TO SCHOOL DISTRICT GUIDELINES.

A NEW PERMISSION FORM IS REQUIRED EACH SCHOOL YEAR FOR EACH MEDICATION TO BE GIVEN.