THE SCHOOL DISTRICT OF GREENVILLE COUNTY

PHYSICIAN'S AUTHORIZATION FOR MEDICATION TO BE GIVEN AT SCHOOL

**** PARENT PERMISSION MUST BE PROVIDED BEFORE MED CAN BE GIVEN ****

NAME OF STUDENT: _____

NAME OF MEDICATION: _____

DOSAGE: _____

TIME OF DAY OR FREQUENCY TO BE GIVEN: _____

MEDICATION IS TO BE (CHECK ONE):

_____ **GIVEN EVERY DAY FOR THE REMAINDER OF THIS SCHOOL YEAR.**

_____ **GIVEN EVERY DAY FROM** _____ (DATE) **TO** _____ (DATE)

CONDITION FOR WHICH MEDICATION IS PRESCRIBED:

_____

_____

PRECAUTIONS, POSSIBLE ADVERSE REACTION AND INTERVENTIONS:

_____

I have seen this child and agree with all the information provided on this authorization form.

_____ PHYSICIAN'S SIGNATURE

_____ DATE

_____ OFFICE ADDRESS

_____ OFFICE PHONE

PLEASE COMPLETE THIS STATEMENT ONLY IF STUDENT IS TO SELF-ADMINISTER

_____ PHYSICIAN'S INITIALS

This student is allowed to self-administer this medication while at school and understands the implications of doing so. He/she has demonstrated competency in self-monitoring and self-administration of this medication. The parents are aware that they can not hold the school district responsible for the adverse outcome of this action.

This student must also be allowed to possess this medication on the following activities. Initial all that apply.

_____ Classroom and any area of the school or school grounds.

_____ A school sponsored activity

_____ In transit to and from school or school-sponsored activity

_____ Before/After-school activity on school property

_____ PHYSICIAN'S SIGNATURE

_____ INITIALS

_____ DATE