MED-3 rev 2010

THE SCHOOL DISTRICT OF GREENVILLE COUNTY

AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION AT SCHOOL

(MUST BE SIGNED BY PARENT)

PLEASE PRINT *SCHOOL YEAR:* _____

STUDENT'S NAME: _____ BIRTH DATE: _____

LEGAL GUARDIAN: _____ DAYTIME PHONE: _____

NAME OF MEDICATION: _____

REASON FOR GIVEN MEDICATION AT SCHOOL. (PLEASE BE SPECIFIC):

_____

AMOUNT OF MEDICATION TO BE GIVEN: _____

DATE TO ***START*** MEDICATION: _____ DATE TO ***STOP*** MEDICATION: _____

TIME OF DAY MEDICATION IS TO BE GIVEN: _____

EXPIRATION DATE OF MEDICATION: _____

POSSIBLE SIDE EFFECTS: _____

STUDENT'S PHYSICIAN: _____ PHONE #: _____

PARENTS: PLEASE READ CAREFULLY:

I understand that all medication will be provided by me in the original container, clearly labeled with my child's name. *I will notify the school 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. I give the school nurse my permission to contact the Physician's office to request medical information concerning my child. I am responsible for replacing medication before the expiration date.

_____ _____

Legal Guardian Date

PLEASE NOTE:

A SEPARATE PERMISSION FORM IS REQUIRED FOR EACH MEDICATION TO BE GIVEN.

PARENTS ARE RESPONSIBLE FOR NOTING THE EXPIRATION DATE OF ALL MEDICATION. EXPIRED MEDICATION WILL NOT BE GIVEN AT SCHOOL

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

ANY OVER-THE-COUNTER MEDICATION GIVEN EVERY DAY FOR 10 CONSECUTIVE DAYS MUST HAVE PHYSICIAN'S AUTHORIZATION.