

## THE SCHOOL DISTRICT OF GREENVILLE COUNTY AUTHORIZATION FOR PRESCRIPTION MEDICATION AT SCHOOL

(MUST BE SIGNED BY PARENT AND PHYSICIAN)

| PLEASE PRINT  | SCHOOL YEAR:  |
|---|---|
| STUDENT'S NAME:   | BIRTH DATE:   |
| LEGAL GUARDIAN:   | DAYTIME PHONE:  |
| NAME OF MEDICATION:   |   |
| REASON FOR GIVEN MEDICATION AT SCHOOL   |   |
| AMOUNT OF MEDICATION TO BE GIVEN:   |   |
| TIME OF DAY MEDICATION IS TO BE GIVEN AT  | r school:   |
| EXPIRATION DATE OF MEDICATION:  |   |
| DATE TO START MEDICATION:   |   |
| DATE TO STOP MEDICATION:  | <del></del>   |
| POSSIBLE SIDE EFFECTS:  |   |
|   |   |
| PHYSICIAN SIGNATURE:  |   |
| OFFICE PHONE #:   |   |
| PARENTS PLEASE READ CAREFULLY:  |   |
| child's name. <u>I will notify the school if the medic.</u> Permission is granted to the principal and/or school neresponsibility for my child. The first dose will be give | ed by me in the original container, clearly labeled with my ation is discontinued or the dosage has been changed. urse to share this information with individuals who have en at home so that I can monitor adverse reactions. I give named Physician's office to request medical information edication before the expiration date. |
| LEGAL GUARDIAN'S SIGNATURE:   | DATE:   |