GREENVILLE COUNTY SCHOOLS
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Greenville County School District Health Services

AUTHORIZATION FOR NON-PRESCRIPTION/OVER THE COUNTER MEDICATION AT SCHOOL

- *Please complete a separate form for each medication.*
- *Medication must be brought to the health room by the parent or responsible adult. Do not send medication with a student.*
- *Medication should be routinely given at home before or after school, whenever possible.*
- *Medication must be provided in a new, unopened container with the manufacturer's label intact (smaller containers preferred).*
- *If the medication dose requested exceeds the manufacturer's recommendations and/or administration of medication will be greater than 10 consecutive days, a Licensed Health Care Provider must complete the Authorization for Prescription Medication at School form (MED-1). Contact your school nurse for more information.*
- *Medication will not be administered without this completed form including parent/guardian signature.*

Student's Legal Name:		Date of Birth:
List Allergies :		
Name of Medication:	Purpose of Medication at School:	
Dose:	Time of day for administration at school:	Route:
Date to Start Medication:	Date to Stop Medication:	
Possible Side Effects:		
Student's Physician:	Phone:	

PARENTS/LEGAL GUARDIANS PLEASE READ CAREFULLY:
By signing below, I understand and agree to the following:

- I understand that all medication will be provided in a new, unopened container with manufacturer's label intact and labeled with my child's name.
- 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 am responsible for replacing medication before the expiration date.
- I give my permission for the GCSD to administer this medication to my child as directed by the manufacturer, according to district requirements.

Parent/Legal Guardian's Signature _____ Date: _____

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

ANAPHYLAXIS MEDICATION AUTHORIZATION

(Must be completed by parent/legal guardian and physician before medication can be accepted at school)

SCHOOL YEAR:_____

STUDENT NAME: _____ Date of Birth:_____

PARENT/LEGAL GUARDIAN: _____

PHONE #1 :	PHONE #2 :

EMERGENCY CONTACTS:

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

PHYSICIAN'S NAME: _____ PHONE #:_____

CHILD IS SEVERELY ALLERGIC TO:_____

MEDICATION TO BE ADMINISTERED AT SCHOOL:

MEDICATION	**DOSE**
☐ DIPHENHYDRAMINE	
☐ EPINEPHRINE	☐ 0.15 MG ☐ 0.30 MG
☐ OTHER	

PHYSICIAN'S SPECIFIC INSTRUCTIONS FOR MEDICATION ADMINISTRATION:

_____

_____

STUDENT MUST CARRY MEDICATION: ☐ YES ☐ NO STUDENT IS ASTHMATIC: ☐ YES ☐ NO

STUDENT IS AT HIGH RISK FOR SEVERE REACTION: ☐ YES ☐ NO

STUDENT IS REQUIRED TO CARRY THIS MEDICATION ON THE BUS: ☐ YES ☐ NO

CHILD'S FIRST SYMPTOMS MAY START AS: (CHECK ALL THAT APPLY)

☐ Itching and swelling of the lips, tongue, or mouth

☐ Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough

☐ Hives, itchy rash, and/or swelling around the face or extremities

☐ Nausea, abdominal cramps, vomiting, and/or diarrhea

☐ Shortness of breath, repetitive coughing, and/or wheezing

☐ "Thready" pulse or passing out

STUDENT NAME: _____

THE SCHOOL DISTRICT WILL PROVIDE TRAINING FOR STAFF AT THE SCHOOL TO ASSIST YOUR CHILD IF NEEDED.

FIELD TRIPS:

☐ I will accompany my child on all field trips away from the school and assume responsibility for administering medication if needed.

☐ The student has permission from the physician to carry and self-administer the medication and will be responsible for having medication available for trips off campus.

☐ The teacher in charge of the field trip will additionally be trained and have responsibility for administering medication if needed.

BUS TRANSPORTATION:

☐ YES, THE BUS DRIVER NEEDS TO BE NOTIFIED ☐ NO, THE BUS DRIVER DOES NOT NEED TO BE NOTIFIED

PARENT/LEGAL GUARDIAN WILL PROVIDE ALL NECESSARY SUPPLIES/MEDICATION AND NOTIFY THE SCHOOL OF CHANGES IN CONDITION OR PRESCRIBED TREATMENT PLAN

I understand that all medication will be provided by me in the original container, clearly labeled with prescription information that lists my child's name. Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. I give the school permission to contact listed physician's office to request medical information concerning my child. I am aware of the expiration date and will replace medication before it expires. If the physician authorizes my child to carry his/her medication during the school day, I understand that I cannot hold the school district responsible for any adverse outcome of this action.

PARENT/LEGAL GUARDIAN SIGNATURE:_____DATE:_____

I HAVE SEEN THIS CHILD AND AGREE WITH THE ABOVE TREATMENT:

PHYSICIAN'S SIGNATURE: _____ DATE: _____

BOTH AREAS MUST BE COMPLETED IF THE MEDICATION IS TO BE CARRIED AND SELF-ADMINSTERED

☐ THIS STUDENT IS TO SELF-ADMINISTER AND SELF-MONITOR THIS MEDICATION WHILE AT SCHOOL. TRAINING HAS BEEN COMPLETED BY THE PHYSICIAN AND THE STUDENT HAS DEMONSTRATED COMPETENCY IN SELF-MONITORING AND SELF-ADMINISTRATION OF THIS MEDICATION. MEDICATION MUST BE WITH STUDENT DURING CLASS TIME AND ANY SCHOOL SPONSORED ACTIVITY. THE PARENT IS AWARE THAT THEY CANNOT HOLD THE SCHOOL DISTRICT RESPONSIBLE FOR ANY ADVERSE OUTCOME OF THIS ACTION.

PARENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

PHYSICIAN'S SIGNATURE: _____DATE: _____

PLEASE DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911. ALERT EMS TO POSSIBLE ALLERGIC REACTION.

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- *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 and narcotic medications 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 HEALTH CARE PROVIDER ONLY - PLEASE PRINT		
Student's Legal Name:		Date of Birth:
List Allergies :		
Name of Prescribed Medication:	Purpose of Medication at School:	
Prescribed Dose:	Prescribed Time of day for administration at school: (specific time i.e. 8:00am, "after breakfast", or "lunchtime")	Prescribed Route:
Date to Start Medication:	Date to Stop Medication:	
Possible Side Effects:		
Licensed Health Care Provider Name : (Print info or stamp is acceptable) Office Address:		Phone: Fax:
Licensed Health Care 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 GCSD Health Services my permission to contact the above named Licensed Health Care 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 GSCD staff to administer this medication to my child according to district requirements.

Parent/Legal Guardian's Signature _____ Date: _____

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