GREER MIDDLE COLLEGE CHARTER HIGH SCHOOL

AUTHORIZATION FOR PRESCRIPTION MEDICATION AT SCHOOL

(MUST BE SIGNED BY PARENT AND PHYSICIAN)

SCHOOL YEAR: _____

PLEASE PRINT

STUDENT'S NAME: _____ BIRTH DATE: _____

LEGAL GUARDIAN: _____ DAYTIME PHONE: _____

NAME OF MEDICATION: _____

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

_____

AMOUNT OF MEDICATION TO BE TAKEN: _____

TIME OF DAY MEDICATION IS TO BE TAKEN AT SCHOOL: _____

EXPIRATION DATE OF MEDICATION: _____

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

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

POSSIBLE SIDE EFFECTS: _____

_____

PHYSICIAN SIGNATURE: _____ *DATE:* _____

OFFICE 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 and/or designee my permission to contact the above-named Physician's office to request medical information concerning my child. I am responsible for replacing medication before the expiration date.

LEGAL GUARDIAN'S SIGNATURE: _____ *DATE:* _____