

GREER MIDDLE COLLEGE CHARTER HIGH SCHOOL

AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION AT SCHOOL

(MUST BE SIGNED BY PARENT)

SCHOOL YEAR: \_\_\_\_\_

**PLEASE PRINT**

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: \_\_\_\_\_

TIME OF DAY MEDICATION IS TO BE GIVEN AT SCHOOL: \_\_\_\_\_

EXPIRATION DATE OF MEDICATION: \_\_\_\_\_

DATE TO **START** MEDICATION: \_\_\_\_\_

DATE TO **STOP** 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 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: \_\_\_\_\_

**PLEASE NOTE**

- A SPECIAL 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.