South Carolina Public School District
Greenville Tech Charter High School
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. (PLEASE BE SPECIFIC):

_____

AMOUNT OF MEDICATION TO BE GIVEN: _____

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

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 health room manager 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 health room manager 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: _____