School Health Services

SCHOOL MEDICATION PERMISSION AND INSTRUCTION

PART I - PARENT PERMISSION

Date: ____________________

Student's Name ______________________________ *Birthdate* ____________________

Address ______________________________ *City* ______________________________

School ____________________ *Grade* __________ *Teacher* ____________________

I hereby request and grant permission for the above named school to supervise the medication routine below prescribed for the above-named child.

We/I hereby release ______________________________, the ______________________________, the Board of Education,
(designated medication administrator) (the above-named school system)
the Principal of school of which said child is the student, any supervisory personnel, their heirs, executors, administrators, or successors, from any and all liability that may arise out of services rendered in dispensing the below named medication.

I further agree to submit a revised statement signed by the physician who prescribes this drug, if any of the information below chart

____
Parent Signature

PART II - OVER THE COUNTER / NON-PRESCRIPTION DRUGS

MEDICATIONS MUST BE IN ORIGINAL MEDICATION BOTTLE

Medication (name, dosage, route) ______________________________

Reason for use: ______________________________

Date to Begin: ____________________ Date to Cease ____________________

Time or intervals dosage of drug is to be administered: ______________________________

Special instructions and/or adverse effects: ______________________________

____

____
Physician signature (if policy requires)

____
Parent Signature

PART III - PRESCRIPTION DRUGS - PHYSICIANS DIRECTIONS

MEDICATIONS MUST BE IN ORIGINAL PRESCRIPTION BOTTLE

Medication (name, dosage, route) ______________________________

Reason for use: ______________________________

Date to Begin: ____________________ Date to Cease ____________________

Time or intervals dosage of drug is to be administered: ______________________________

Special instructions and/or adverse effects: ______________________________

____

Special instructions (including sterile conditions & storage): ______________________________

____

Adverse effects to report (if any): ______________________________

Telephone number(s) at which physician can be reached in an emergency: ______________________________

Doctor requests teacher=s comments: ______ **NO -- Teacher comments are not necessary

______ **YES** -- Please observe the following: ______________________________

____

____
Physician's Signature

GREENVILLE CITY SCHOOLS
MEDICATION ADMINISTRATION RECORD

School Year: ______________ Grade: _____ Teacher: ____________________ Doctor: _________________
Student: _________________________ DOB: ___/___/___
Medication, Dose, Time:____________________________

CODE

: Weekend	F: Field Trip
: Holiday/No Sch.	D: Early Dismissal
A: Absent	W: Dose Withheld
N: None Available	O: No Show

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
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Jan																															
Feb																															
Mar																															
Apr																															
May																															
June																															

	Date	Count	Initials	Date	Count	Initials	Date	Count	Initials
School Employee ____ ________________									
School Employee ____ ________________									
School Employee ____ ________________									
School Employee ____ ________________									
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