SOUTH CAROLINA GOVERNOR'S SCHOOL FOR SCIENCE + MATHEMATICS

# Permission for Administration of Prescription Medication

**Requires Health Care Provider's Signature**

_____ _____ _____

**Student's Name** **Date of Birth** **Grade**

Medication to be given at GSSM should be accompanied by this form, complete with the prescribing physician's signature; and provided to the school with medication in the original labeled container provided by the pharmacist who filled the prescription. "Sample" medications must be provided in a container that appropriately identifies the medication and must be accompanied by a note signed and dated by the prescribing health care provider that includes the student's name, directions for proper administration, and the name, address, and phone number of the prescribing health care provider.

| | |
|---|---|
| Medication: | Dosage; |
| Purpose of Medication: | Route: |
| Time(s) medication to be given: | Frequency: (e.g. daily) |
| Anticipated number of days medication will be given:<br>O until end of school year<br>O ____weeks<br>O ____days | Possible Side Effects: |
| Is child allergic to any food, medicines, or other items? O No O Yes (List allergies) | Is this medication a controlled substance?<br>O No O Yes |

**X**_____ _____

**Prescribing Health Care Provider's Signature** **Date**

| | |
|---|---|
| Stamp, Print, or Type Health Care Provider's Name & Address: | Office Phone Number:<br><br>Office Fax Number: |

**Section below to be completed by child's parent/guardian:**

I give permission for my child, _____, to be given the above medication as prescribed. I give permission for the school nurse to contact the health care provider named above, or the pharmacist to fill the prescription, to discuss this medication and my child's health. I give permission for the health care provider named above, the pharmacist, and/or their designated employees to provide information about this medication and my child's health to the school nurse. I understand that the school may require that I agree to the school's rules about medications before this medicine will be given at school. I understand that I am responsible for notifying the school if my child's medications change in any way.

_____ _____

Signature of Parent/guardian Date

_____ _____

Print Name of Parent/guardian Date

**Additional copies of this form may be made. We must have a different form for every prescription.**