



Permission for Administration of Prescription Medication
Primary Care Physician must sign

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.

Child's Name _____		Date of Birth _____	
SC Governor's School for Science and Mathematics		Grade : _____	
Medication:	Dosage;		
Purpose of Medication:	Route:		
Time(s) medication to be given:	Frequency: (e.g. daily)		
Anticipated number of days medication will be given: <input type="radio"/> until end of school year <input type="radio"/> ___ weeks <input type="radio"/> ___ days	Possible Side Effects:		
Is child allergic to any food, medicines, or other items? <input type="radio"/> No <input type="radio"/> Yes (List allergies)	Is this medication a controlled substance? <input type="radio"/> No <input type="radio"/> Yes		

X _____

Prescribing Health Care Provider's Signature	Date
Stamp, Print, or Type Health Care Provider's Name & Address:	Office Phone Number: 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 Phone number

Additional copies of this form may be made. One prescription per form.