

**GREENEVILLE CITY SCHOOLS
COORDINATED SCHOOL HEALTH
PERMISSION FOR MEDICATION ADMINISTRATION
(PRESCRIPTION AND NON-PRESCRIPTION)**

Many children and adolescents require medication to maintain an optimal level of functioning at school. While we encourage parents to give medication(s) at home, we understand that in some situations medication must be given at school. **Medications must be brought to school by the parent/guardian in the original container with this signed permission form attached.** It is the responsibility of the parent/guardian to remove any unused medication from the school within 7 days of the last day of scheduled administration or the medication will be discarded by the school nurse. **NO MEDICATION WILL BE SENT HOME BY STUDENTS.**

Student Name _____ Date of Birth _____

School _____ School Year _____ Grade _____

Allergies _____

Name of medication _____ Strength _____ Dosage _____

Route of administration (by mouth, topical, inhalation, etc.) _____

Please Check one: As Needed _____ Daily _____ Time _____

Date started _____ Date to be discontinued _____

Purpose of medication _____

Possible side effects _____

Special Instructions _____

_____ IS competent to self-administer his/her medication with the assistance of trained school
(Student name) personnel.

_____ IS NOT competent to self-administer his/her medication and will require medication to
(Student name) be administered by the school nurse/trained school personnel or parent.

I give permission for personnel of Greeneville City Schools to contact prescribing healthcare provider in the event there are questions about the medication(s). The healthcare provider has my permission to discuss the medication, diagnosis, side effects, etc. with Greeneville City School personnel.

Unless otherwise specified, the duration of this consent will be for the entire school year.

Custodial Parent/Guardian Signature _____ Date _____

Cell Phone _____ Home phone: _____ Work Phone _____
(This form is required for all medications –prescription and non-prescription)

Emergency Contact _____ Phone _____

Physician Signature _____ Date _____ Phone _____
(Required for medications that are to be administered on a regular basis longer than a four week period)