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

Many children and adolescents require medication to maintain an optimal level of functioning at school. Whenever possible, we encourage that medication(s) be given at home. We understand that in some situations medication must be given at school. **Medications must be brought to school by the parent/guardian 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
(Student name) assistance of trained school personnel.

_____IS NOT competent to self-administer his/her medication and
(Student name) will require medication to be administered by the school nurse/licensed 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)