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Gaffney, SC 29340
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Gaffney, SC 29342
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Request For Medication (Prescription and Over-the-Counter) To Be Given During School Hours Or On School Sponsored Overnight or Extended Field Trips

Student _____ Date of Birth _____ Grade __ Allergies _____

Medication_____ Dosage_____ (No injection will be given except in extreme emergency, such as allergic reaction or asthma.)

Time of medication administration: AM. ___ PM. ____ Start Date _____ End Date _____

Special instructions or possible adverse reactions: (Please list)
_____ ☐

☐ School to administer medication

☐ If prescription is for EPI-PEN, INHALER or INSULIN student may self-carry and self-administer the medicine. I have provided education and he/she is knowledgeable and has demonstrated the necessary skill level for this medication.

_____ _____ _____
Physician's Signature Date Telephone Number

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. I understand that in many cases non-medical personnel will administer the medication. A licensed physician has prescribed this medication and I hereby release the School Board, their agents and employees from all liability that may result from my child taking the prescribed medication.

I will furnish this medication in a container properly labeled by a pharmacist with identifying information (i.e.name of child, medication dispensed, dosage prescribed, and the time it is to be given.)

_____ _____ _____
Parent or Guardian Signature Date Telephone number

The Form and Medication must be returned to the front office one week prior to the field trip.

Reviewed By: _____ _____