**Student Life Office**
**15 University Street, Greenville, South Carolina 29601 p: 864.282.3848 f: 864.282.3849 Email: registration@scgsah.org**

# Summer MEDICATION REGISTRY 2024

**Due: May 18th**

**Student:** **Mr. Miss (Circle One)**

SC Governor's School for the Arts and Humanities

**Last** **First** **Middle** **Preferred**

## Over-the-Counter Medications

**All over-the-counter, prescription medications and supplements must be supplied by parent/guardian and will be maintained in the Health Office. Please note ALL medications must be in their original container and will be labeled with your child's name.**

| Over-The-Counter Medication/Supplement | Please Place Your Initials in the Block Beside the Medicine Your Child May Have At School |
|---|---|
| Naproxen (i.e. Aleve) | |
| OTC Migraine Medication (i.e. Excedrin) | |
| Acetaminophen (i.e. Tylenol) | |
| Ibuprofen (i.e. Motrin) | |
| Diphenhydramine Hydrochloride (i.e. Benadryl) | |
| Loratadine (i.e. Claritin) | |
| Cold Medication (includes Cough Meds and Decongestants) | |
| Stool Softener/Laxative (i.e. Dulcolax) | |
| Stomach Medication (i.e. Pepto-Bismol/ Milk of Magnesia) | |
| Menstrual Cramp Medication (i.e. Pamprin) | |
| Vitamin Supplements (List): | |
| Melatonin | |
| Other OTC: | |
| Other OTC: | |
| Other OTC: | |
| Other OTC: | |

**I give permission for medications checked above to be given, as needed per package directions.**

**Parent/Guardian Signature** **Date**

# Summer MEDICATION REGISTRY 2024

**Student:**

| Last | First | Middle | Preferred |
|---|---|---|---|

## Permission/Authorization for Prescription Medications to be given at school

| Medication | Dose | Frequency | Parent/Guardian's Initial | Physician's Initial |
|---|---|---|---|---|
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I give permission for my child to be given the above medication as prescribed. I give permission for the school nurse or a school administrator to contact the health care provider named above or the pharmacist who filled 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 or school administrator. I understand that I am responsible for notifying the school if my child's medications change in any way. I understand this medication must be kept in the SCGSAH Health Office. **Note: Please contact the school nurse for a self-administration permission form for birth control pills, asthma inhalers, insulin and EpiPens.**

## Signature of Parent/Guardian

| Signature | Date |
|---|---|

## Physician Completing Form

**(All information must be provided.)**
**Physician's signature required only if there are prescription medications.**
**Please list and initial all prescription medications ordered for administration.**

| Physician's Name Printed | Physician's Signature |
|---|---|
| Practice Name | Date Exam Completed |

| Mailing Address | City | State | Zip |
|---|---|---|---|

| Telephone Number | Fax Number |
|---|---|