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

MEDICATION REGISTRY 2024-2025

Due: May 31st

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 (including 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**

MEDICATION REGISTRY 2024-2025

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

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