



Administration of Medication Form

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ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL CONSENT

INSTRUCTIONS: This form must be filled out and signed annually by the *student, parent/guardian, and physician* before this medication can be administered during school hours. Please fill out **one form per medication**.

STUDENT NAME: _____

DATE OF BIRTH: _____

GRADE: _____

MEDICATION: _____

CONDITION FOR WHICH MEDICATION WAS PRESCRIBED: _____

POSSIBLE SIDE EFFECTS: _____

INSTRUCTIONS FOR USE: _____

DOSAGE: _____

Time: _____

ROUTE: _____

FREQUENCY: _____

NAME OF PARENT/GUARDIAN: _____

I understand and agree to the following:

I agree to assume responsibility for sending my child's medication in its original prescription container.

I agree to make certain that my child takes responsibility for taking the medication as prescribed.

I also agree that the Southeastern California Conference, La Sierra Academy, and all its employees shall not be liable for any loss, damage, injury, or liability of any kind to any person caused or arising from acts, omissions, or negligence of the school or its employees relating to the self-administered medication by my child.

I HAVE READ AND UNDERSTOOD THIS FORM AND CONSENT TO THE ABOVE PROVISIONS.

Signature of *Parent or Guardian*

Date

NAME OF PHYSICIAN: _____

This student is under my care and needs to carry this medication during school hours and activities. I have given the student instructions for administration of this medication and give authorization for the self-administration of this medication.

(Note: Authorization is needed for non-prescription medications, also.)

Address: _____

Signature of *Physician*

Date

Phone: _____