ADMINISTRATION OF MEDICATION FORM

LA SIERRA ACADEMY | 4900 GOLDEN AVENUE, RIVERSIDE, CA 92505 | P • 951-351-1445 | F • 951-689-3708

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 **one form per medication.**

STUDENT NAME: ____

DATE OF BIRTH: ____________________ **GRADE:** ____________

CONDITION FOR WHICH MEDICATION WAS PRESCRIBED:

____

____

MEDICATION:

____

INSTRUCTIONS FOR USE:

____

____

DOSAGE: ____

ROUTE: ____

FREQUENCY: ____

POSSIBLE SIDE EFFECTS:

____

____

THIS MEDICATION SHOULD BE TAKEN WITH THE STUDENT ON:

(CHECK ALL THAT APPLY)

☐All Field Trips

☐After School Care

☐5th grade Astro Camp

☐6th grade Out Door School

☐7th grade Catalina Trip

☐8th grade Washington DC Trip

☐Jr. High & High School Sporting Activities

☐High School Music Tour

☐High School Mission Trip

☐Other: ______________________________

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: ______________________________

Revised February 12, 2021

DISPOSITION OF MEDICATION: RETURNED TO PARENT (INITIAL) __________ DATE: ________