FOUNDED 1922

ADMINISTRATION OF MEDICATION

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

SELF-ADMINISTRATION OF MEDICATION CONSENT FORM

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: _____

STUDENT:

I agree and feel competent to take my own medication as prescribed. I will not at any time share my medication with another student and I will keep medication secure from other students.

_____ _____

Signature of *Student* Date

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: _____