



SELF-ADMINISTRATION OF MEDICATION

LOMA LINDA ACADEMY | 10656 ANDERSON ST. LOMA LINDA, CA 92354 | P • 909-796-0161 | F • 909-799-3766

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:

THIS MEDICATION SHOULD BE TAKEN WITH THE STUDENT ON:
(CHECK ALL THAT APPLY)

☐ All Field Trips

MEDICATION: _____

☐ All Overnight Field Trips

INSTRUCTIONS FOR USE:

☐ After School Care

☐ JH & HS Sporting Activities

DOSAGE: _____

☐ Other: _____

ROUTE: _____

TIME: _____

FREQUENCY: _____

HOW LONG (number of days): _____

POSSIBLE SIDE EFFECTS: _____

STUDENT NAME: _____

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 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, Loma Linda 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 (over the counter) medications, also.**

Signature of Physician

Date

Address: _____

Phone: _____