ADMINISTRATION OF MEDICATION

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

ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL CONSENT FORM

INSTRUCTIONS: This form must be filled out and signed annually by the *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:

_____

_____

THIS MEDICATION SHOULD BE TAKEN WITH THE STUDENT ON: (CHECK BELOW)

☐All Field Trips
☐All Overnight Field Trips
☐After School Care
☐Other: _____

DOSAGE: _____
ROUTE: _____
TIME: _____
FREQUENCY: _____
HOW LONG(number of days): _____
POSSIBLE SIDE EFFECTS: _____

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 and request that it be given to my child as prescribed.

I release Southeastern California Conference, Loma Linda Academy and all its employees from any liability in relation to the administration of this medication.

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

_____ _____
Signature of Parent or Guardian **Date**

NAME OF PHYSICIAN: _____

I have prescribed the following medication for this child and request that dosage falling during school hours be administered by school personnel. NOTE: Authorization is needed for non-prescription (over the counter) medications, also.

Address: _____
_____

_____ _____
Signature of Physician **Date**

Phone: _____

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DISPOSITION OF MEDICATION: RETURNED TO PARENT (INITIAL) _____ DATE: _____