



SELF-MEDICATION ADMINISTRATION CONSENT FORM.

Instructions: This form must be filled out and signed annually by the student's parent or guardian before the student will be allowed to carry and administer medication.

Student's Full Name _____

Date of Birth _____

School _____ Grade _____ Teacher _____

Parent's Work Phone _____ Home Phone _____ Cell Phone _____

MEDICATION(S)

1. _____
2. _____

I understand and agree to the following:

1. I agree to assume responsibility for sending my child's medication in its original prescription container.
2. I agree to make certain that my child takes responsibility for taking the medication as prescribed.
3. I also agree that the Southeastern California Conference, the school and/or their employees shall not be liable for 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

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 it secure from other students.

Signature of Student

Date

Name of Physician _____

This student is under my care and needs to carry this medication with him/her while at school. I have given the student instructions for administration of this medication and give authorization for the self-administration of this medication.

Signature of Physician

Date