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 Telephone ______________ Parent's Home Telephone ______________

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 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**

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**