MONTE VISTA CHRISTIAN SCHOOL

PRESCRIPTION MEDICATION FORM

Signature of both physician and parent/guardian are required. This form must be renewed annually or with any change in medication.

Any student who is required to take medication prescribed by a physician may be assisted by a school nurse or other designated school personnel.

All medication must be provided to the school in the original container from the pharmacist, complete with the physician's directions on the container detailing the method, amount, and time schedule by which the medication is to be taken.

Please note that all prescription medications must be prescribed by a physician licensed in the state of California.

Student Name: _____ **Date of Birth:** _____

TO BE COMPLETED BY THE PHYSICIAN:

Reason for Administration/Diagnosis: _____

Medication Name: _____ Dose: _____

Time (or frequency if given as needed): _____ Route: _____

Special Instructions (i.e. storage and important side effects): _____

Physician Signature: _____ Address: _____

Physician Name: _____ Phone: _____ Date: _____

TO BE COMPLETED BY THE PARENT/GUARDIAN

Name of pharmacy filling prescription: _____ Phone: _____

In signing this form, as the parent/guardian, I agree to hold Monte Vista Christian School and its employees harmless from any and all liability resulting from the administration of medication in the manner directed. I also provide release for the school nurse or other designated school personnel to communicate with the health care provider and/or pharmacist of the student regarding any questions that may arise with regard to the medication.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Phone Numbers: _____ or _____