MONTE VISTA CHRISTIAN SCHOOL

SELF-ADMINISTERED MEDICATION FORM

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

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): _____

The student is under my care and needs to carry this medication with him/her while at school. I agree that the student is capable of self-administration and is able to manage this medication responsibly.

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____ Address: _____

TO BE COMPLETED BY THE PARENT/GUARDIAN:

Name of pharmacy filling prescription: _____ Phone: _____

In signing this form, as the parent/guardian, I give permission for my child to carry and self-administer the above medication. I agree to hold Monte Vista Christian School and its employees harmless from any and all liability resulting from the self-administration of medication by my child. 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 _____