VACAVILLE CHRISTIAN SCHOOLS

1117 Davis Street, Vacaville, Ca (707) 446-1776

Medication Authorization Form

Student Name_____Grade_____ DOB_____

Please assist my child in taking the provided medication as indicated. School personnel have my permission to communicate with my child's physician, and may provide information regarding the possible effects of the medication on my child. I will notify the school immediately if my child's physician makes any medication changes. **I understand medication will be discarded after two weeks of discontinued use.**

_____

Parent/Guardian Signature Date Daytime Contact #

RELEASE of the Administration of Student Medications

School personnel will administer physician prescribed medications during school hours. The primary responsibility of the student taking medication rests entirely with the parents and student. **MEDICATION MUST BE IN THE STUDENT'S NAME AND IN THE ORIGINAL CONTAINER. ALL MEDICATIONS WILL BE KEPT IN THE SCHOOL OFFICE.**

PRESCRIBING PHYSICAN, PLEASE FILL OUT THE BOX BELOW FOR PRESCRIPTION MEDICATIONS

MEDICATION_____ AMOUNT: _____

Reason:_____

Side Effects:_____

Time: ____AM_____PM or _____Only as needed; every _____hour(s)

ROUTE (check one) : _____Oral_____Inhale_____Eye (R or L) _____Ear (R or L) ____Other_____

PRINT PHYSICIAN NAME_____ PHONE_____

PHYSICAN SIGNATURE_____ DATE_____

PARENT/GUARDIAN – PLEASE FILL OUT THE BOX BELOW FOR NON-PRESCRIPTION MEDICATIONS

MEDICATION_____ DOSE_____

Reason:_____

Time: ____AM_____PM or _____Only as needed; every _____hour(s)

ROUTE (check one) : _____Oral_____Inhale_____Eye (R or L) _____Ear (R or L) ____Other_____

I understand that non-prescription medications must be brought to the school in the original sealed container and labeled with my child's name, weight and date of birth. I release and will hold Vacaville Christian Schools and school personnel harmless for any illness, death, and damages that can or might occur due to the administration of my child's medication. I agree to pick up the medication as soon as my child no longer needs it. **OVER THE COUNTER MEDICATIONS WILL BE GIVEN ACCORDING TO CONTAINER INSTRUCTIONS**. **Medications left in the office at the end of the school year will be discarded.**

Print Parent Name_____

Parent Signature_____ Date_____