PERMISSION FOR SCHOOL PERSONNEL TO ADMINISTER MEDICATION

LOS ALTOS CHRISTIAN SCHOOL
625 MAGDALENA AVE.
LOS ALTOS, CA 94024
(650) 948-3738

STUDENT NAME	DATE OF BIRTH	EMERGENCY PHONE NUMBER
TEACHER	GRADE	DATE

MEDICATION INFORMATION

NAME OF MEDICATION	CONDITON TREATED BY MEDICATION
DOSAGE TIME	HOW LONG WILL CHILD NEED MEDICATION?
IS MEDICINE NECESSARY FOR CHILD TO REMAIN IN SCHOOL? YES ☐ NO ☐	SPECIAL STORAGE REQUIREMENTS
SIDE EFFECTS EXPECTED	POSSIBLE SIDE EFFECTS

Is the child fully aware of doctor's orders as well as his/her own responsibility for taking the medication? YES ☐ NO ☐

Describe any administration condition/procedures that those giving the medication should be aware of: _____
_____

PARENTS/GUARDIANS: We realize it may be important for a student's health and well-being that medication be taken at school. It is also important that such medicines be approved and that the administration of medication follows school policy and physician's written authorization. This form is required for all medication, prescription and over-the-counter, that is to be taken at school. A separate form is required for EACH medication. Prescriptions must be in original container with dosage and student's name.

AUTHORIZED SIGNATURE

PARENTS/GUARDIANS: Signature indicates the accuracy of the above information, permission for Los Altos Christian School to administer the above medication to your child according to doctor's orders and school policy, your understanding of school policy for the administration of medications, and your child's understanding of his/her responsibility involving this medication.

Please Print: Parent or Guardian's Name_____

Signature _____ **Date** _____