

MEDICATION SELF ADMINISTRATION CONSENT

Dear Parent or Guardian:

Because of liability factors involved with dispensing prescription medication and school policy, we are unable to comply with any requests to administer prescription medication unless this form has been completed by both the parent and the physician. We are sure you understand how important it is for this to be handled in a consistent, structured manner. Upon receipt of the completed form, we will follow the indicated procedures in administering prescription medication to your child. Thank you for your cooperation.

CHILD'S NAME: _____ Birthdate: _____

Physician's order for prescription medication at school

I have determined that the following prescription medication must be taken during school hours:

Medication: _____

Dose & Frequency: _____

Route of Administration: ___PO___ INHALE___ INJECTION___

Purpose of Medicine: _____

Side Effects: _____

Other medication child is taking: _____

Date of order: _____ Discontinue Date: _____

Dr.'s Printed name: _____

Dr.'s Signature: _____

USE SEPARATE SHEET FOR EACH MEDICATION

I absolve TCS of all liability in administering the above medication.

Parent or Guardian Signature

Date

TRINITY CHRISTIAN SCHOOL PRESCRIPTION MEDICATION POLICY

When a child requires prescription medication, the primary responsibility for administering such medication rests solely upon the parents. The school recognizes that some short and long term conditions can be controlled or corrected only when medicated at intervals which may include school hours. In those instances, when the doctor has determined that administration during school hours is necessary for optimum benefits, the school endorses the following procedure:

1. Medications are defined as registered prescription drugs.
2. The physician will complete the order for medication.
3. The parent and Physician will complete the Medication Self Administration Consent form.
4. Medication will be in the original container or prescription bottle appropriately labeled by the pharmacist, physician or manufacturer.
5. Medication will be stored in school office.
6. For students participating in field trips and after school activities, their medication will be monitored by adult supervisors.

Parent Consent for Student to Administer Medication at School

I hereby request that Trinity Christian School allow my child to self administer the medication at the left and ordered by Dr. _____

Medication Name: _____

I can be reached at the following telephone number(s) in case there is a problem or question.

Phone Number _____ Cell phone: _____

I understand that my child is responsible for the administration of this medication.

Parent or Guardian Signature

Date