Victor Valley Seventh-day Adventist School
Where Excellent Education and Core Christian Concepts Meet
17137 Crestview Drive, Victorville, CA 92395 (760) 243-4176 Fax: (760) 245-5606 vvsda.com

SELF-MEDICATION ADMINISTRATION CONSENT FORM

Instructions: This form must be filled out and signed annually by the student's parent or guardian before the student will be allowed to carry and administer medication.

Student's Full Name _____

Date of Birth _____

School _____ Grade _____ Teacher _____

Parent's Work Telephone _____ Parent's Home Telephone _____

MEDICATION(S)

1. _____
2. _____

I understand and agree to the following:

1. I agree to assume responsibility for sending my child's medication in its original prescription container.
2. I agree to make certain that my child takes responsibility for taking the medication as prescribed.
3. I also agree that the Southeastern California Conference, the school and all its employees shall not be liable for any loss, damage, injury, or liability of any kind to any person caused or arising from acts, omissions or negligence of the school or its employees relating to the self-administered medication by my child.

I HAVE READ AND UNDERSTOOD THIS FORM AND CONSENT TO THE ABOVE PROVISIONS.

_____ _____
Signature of Parent or Guardian **Date**

I agree and feel competent to take my own medication as prescribed. I will not at any time share my medication with another student and I will keep it secure from other students.

_____ _____
Signature of Student Date

Name of Physician _____

This student is under my care and needs to carry this medication with him/her while at school. I have given the student instructions for administration of this medication and give authorization for the self-administration of this medication.

_____ _____
Signature of Physician Date