CALVARY CHRISTIAN ACADEMY

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

(Education Code Section 49423)

I, the undersigned, as a legal parent/guardian of ____
Student Name

attending Calvary Christian Academy request that the prescribed medication(s) listed below be made available to my child at the prescribed times (also listed below).

I understand that only personnel authorized by the school will assist my child in taking the medicines as directed by a physician.

I will provide the medication(s) *in the prescription container(s),* labeled with the child's name, prescribing physician's name, and amount of medication prescribed.

I understand and agree that if any of the conditions in the Physician's Statement change, a new form, signed and completed by the parent/guardian and physician, must be submitted.

Prescription medications are not permitted to be taken at school without a written statement from the physician and a written statement from the parent requesting that the school assist the student as set forth in the Physician's Statement below.

This form is only valid for the following school year:

____

I recognize and understand that this is a service or accommodation which the school is not legally required to perform. I agree to hold Calvary Christian Academy, Calvary San Diego, its officers, employees, or agents harmless from all liability, suits, or claims, of any nature or kind, which might arise as a result of administering medications in accordance with this request.

______________________ ____________
Parent Signature Date

____
Address

(____)__________________ (____)________________
Work Phone Home Phone

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Information below this line to be completed by a physician licensed in the State of California

1.	Name of Medication	Method of Administration	Dosage	Approx. Time of Day
A				
B				

2. Discontinue Medication "A" on _________________ and Medication "B" on __________________.
Date Date

3. Please describe the type of assistance required for administering medication (observe, measure, etc.)

____

4. Precautions for Administration or Storage of Medication ______________________________

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Medical License Number ________________ Physician Name ______________________________
Please Print

Physician Signature ____________________ Date ______________ Phone______________________