BIG VALLEY CHRISTIAN SCHOOL
4040-D Tully Road, Modesto, CA 95356
Preschool - Elementary (209) 527-3481
Junior High - High School (209) 571-4800 Fax (209) 529-1748
*A Ministry of Big Valley Grace Community Church*

# MEDICATION CONSENT

***Each medication needs a separate form.***

This form must be filled out by a physician after July 1st for any medication, prescription or non-prescription, for the new school year.

Date: _____

Student name: _____ Birth date: _____ Grade: _____

Name of medication: _____

Reason for medication:_____

When to give medication/symptoms: _____

Amount to be given: _____ Time to be given: _____

Additional instructions:_____

Possible reaction that needs to be reported to physcian: _____

Dates this medication will need to be taken: From: _____To:_____

FOR INHALER USE ONLY:
This student must carry his/her inhaler with them during the school day. __Yes __ No _____ (Physcian Init.)

NAME OF PHYSICIAN (Please Print): _____ Phone: _____

SIGNATURE OF PHYSICIAN: _____ Date: _____

## ADMINISTRATIVE STATEMENT

Parent Release for Administration of Medication

I, the undersigned, who is the parent of _____ request that a member of the school staff administer medicine to my child in accordance with the above request. I understand that the primary responsibility for my child taking this medication rests entirely on my child and me. It is understood that the school is not legally obligated to administer medication to my child; therefore, I agree to hold Big Valley Christian Schools and its employees free from any or all suits which might arise out of these arrangements. I or my 7th - 12th grade student will deliver the medication to the school office.

I will notify the school if the medication is changed or stopped. The medication to be taken at school will be furnished in its pharmacy labeled bottle or original container. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the end of the school year.

I give my consent for school personnel to exchange medical information with the prescribing physician.

Date:_____ Parent's Signature: _____

Home Phone: _____ Work Phone:_____ Cell Phone:_____

(OFFICE USE ONLY: TO BE COMPLETED BY STAFF RECEIVING MEDICATION)

Signature: _____ Date: _____

Name of medication: _____ Number of tablets or oz. received: _____