



S a n t a F e C h r i s t i a n S c h o o l s
 838 Academy Drive Solana Beach, CA 92075 858.755.8900 www.sfcs.net

**AUTHORIZATION FOR SFCS TO ADMINISTER MEDICATION TO MY CHILD
 (Education Code Section 494423)**

I(We), the legal parent(s)/guardian(s) of _____,
(Student's Name) (Grade/Teacher)
 attending Santa Fe Christian School request that the following medication (s):

- _____
- (name of medication) (method of administration) (dosage) (time to be given) (reason for medication)
- _____
- (name of medication) (method of administration) (dosage) (time to be given) (reason for medication)
- _____
- (name of medication) (method of administration) (dosage) (time to be given) (reason for medication)

be made available to my child while s/he is at school. I understand that only personnel authorized by the school principal will assist my child in taking the medication as directed by my physician. I have conferred with my physician to arrange the medication time intervals to avoid school hours whenever possible. I authorize the school personnel to contact my physician as needed. **I will provide the medication in the original pharmaceutical-dispensed and properly labeled container which is labeled with the name of my child, the prescribing physician, the amount of medication to be given, and the times that it should be given to my child (this includes any over-the counter medications too).** I understand that if any of the conditions in the physician statement below change, I must obtain another form signed by my physician. I recognize the fact that this is a service or accommodation which the school is not legally required to perform. I agree to save and hold the school, its employees or agents harmless from liability suits or claims, or whatever nature or kind, which might arise as a request of administering the medication in accord with this request. If the above medications are to be self-administered by the student and/or carried upon their person while at school, I understand that my physician must complete a separate authorization form to carry their medication with them while on school property.

Please be aware of the following precautions when administering or storing the above medications (please include any adverse responses to be observed):

_____ Signature of Parent/Guardian	_____ Date	_____ Home Phone/Cell Phone
_____ Printed Name of Physician Licensed in State of California	_____ Date	_____ Office Telephone Number
_____ Signature of Physician	_____ California Medical License Number	