

**HUENEME CHRISTIAN SCHOOL, INC.
312 NORTH VENTURA ROAD
PORT HUENEME, CA 93041
(805) 488-8781 FAX: (805) 488-2891**

AUTHORIZATION FOR ANY MEDICATION TAKEN DURING SCHOOL HOURS

Teacher: _____ School Year: _____ to _____

Name of Student: _____ Birth date: _____

Purpose of Medication (**Diagnosis**): _____

Name of Medication: _____
(This includes all prescription and non-prescription medications)

Dosage Prescribed: _____ Time Schedule: _____

Medication to be continued until _____ (Date)

I request that my child be assisted in taking the above medication by school personnel.
The above medication will be administered during school hours and may be administered by medically untrained school personnel whenever necessary.
This is a service that the school is not legally required to perform and is recognized by all parties signing this form, and in so signing they agree to hold the school and its personnel free from any or all claims, damages, demands, suits, or expenses arising out of any injury or death of any person that might arise out of these arrangements.

ALL medications must be in the **ORIGINAL LABELED** bottle with the printed directions and the child's name on it. If any changes are to be made at a later date with prescription medication, we will need a note from the physician stating changes.

Parent's Signature Date

HCS Form 40

PHYSICIAN FORM:

The pupil named above for whom this medication is prescribed is under my care.
The above medication is being prescribed for _____ (**Diagnosis**)
and is considered noncontagious after 24 hours.

Name of Physician _____

Address _____ City _____

Phone Number _____

Signature of Physician _____ Date _____