Berean Christian High School

2018-2019

Medication Release

(To be filled out and signed annually)

Part I: *NON-PRESCRIPTION MEDICATION*

Must be completed by parent/guardian.

I understand and agree to the following:

1. To assume responsibility for sending my child's **non-prescription** medication in its original packaging or original container with your **student's name clearly labeled**.
2. To make certain that my child takes responsibility for taking the medication as directed and my child keeps medication away from other students.

I also agree to release Berean Christian High School Board and its employees from any claims or liabilities connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance.

Name of Student_____Birthdate_____

Name of *Non-Prescription* Medication:_____

Parent/Guardian Contact Phone ( )_____ ( )_____

School **BEREAN CHRISTIAN HIGH SCHOOL** Grade (*2018-2019 School Year*) _____

Parent/Guardian Signature_____ Date_____

Relationship_____

Part II: *PRESCRIPTION MEDICATION*

Must be completed by prescribing physician.

Name of Student_____Birthdate_____

Medication_____

Medication Amount (Dose)_____

Method of Administration _____Frequency _____

Please check below if relevant.

☐THIS STUDENT IS REQUIRED TO CARRY THIS MEDICATION ON HIS/HER PERSON FOR SELF-ADMINISTRATION.

Remarks _____

Physician's Name_____ Physician's Phone_____

Address_____

Physician's Signature_____Date_____

……

Transport of medication, Non-Prescription or Prescription, requires delivery to the BCHS Office and pick-up from the BCHS Office by Parent/Guardian ONLY.