

REFORMATION LUTHERAN CHURCH & SCHOOL

REV. JAMES WERNER
Pastor
(858) 279-3311 or (858) 750-8838
WernerJ@RefSD.org

PRINCIPAL MICHAEL ROSS
Preschool - 8th Grade
(858) 279-3311
Principal@RefSD.org

MRS. BRENNAN BUTH
Preschool & Child Care Director
(858) 279-3311 or (858) 926-6250
BailesB@RefSD.org

Medical Consent Form

I, _____, give my consent for Reformation Staff, who work at
(Print name of authorized representative)

Reformation Lutheran Church and School at 4670 Mt. Abernathy Ave, San Diego, CA 92117 to

administer:

_____ to my child, _____.
(Print name of medication) (Print name of child)

*****Specific instructions to be completed on back of this form*****

In addition, I certify that I have personally instructed the appropriate staff on how to administer the medication to my child.

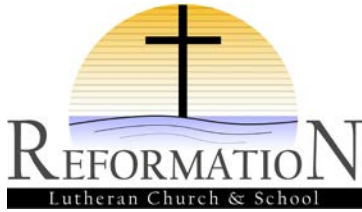
If necessary, I have also provided the facility with written instructions from my child's physician, or from a health care provider working under the supervision of my child's physician (for example, a physician's assistant, nurse practitioner or registered nurse). These instructions include:

- Specific indications (such as symptoms) for administering the medication in accordance with the physician's prescription.
• Potential side effects and expected response.
• Dose form and amount to be administered in accordance with the physician's prescription.
• Actions to be taken in the event of side effects or incomplete treatment response in accordance with the physician's prescription. This includes actions to be taken in an emergency.
• Instructions for proper storage of the medication.
• The telephone number and address of the child's physician.

Signature of authorized representative _____

Date _____

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Medicine Provided: _____
(school has some generic medicines on site)

Yes

No

Dosage: _____

Frequency: _____

Teacher's Initials: _____ time: _____
(when each dosage is given)

Teacher's Initials: _____ time: _____

Call for permission first?
(please check one)

Yes

No

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