Incidental Medical Services Consent and Verification of Service Plan

I, ____, give consent for the licensee, First Baptist Christian Schools, who works at FBCS 3535 N. El Dorado Street, Stockton, CA 95204, to administer incidental medical services and/or medication to my child, ____, and to contact my child's health care provider.

_____ I certify that I have personally instructed the above-named licensee or staff persons on how to administer the medication to my child according to the attached physician's orders following all generally accepted safety precautions. I understand that at least one of the persons designated and trained to carry out the physician's medical orders will be onsite or present at all times when my child is in the care of FBCS.

_____ I certify that I have provided current, written medical instructions from my child's physician which include the following:

- 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.

_____ I understand that my child's medication will be transported with him/her during any campus evacuation and/or field trip.

_____ I understand that it is my responsibility to communicate any new physician's orders (i.e. dosage changes, etc.) and to track expiration dates and replace medicine and/or equipment/supplies as needed.

Name of Medication: ____

Location of Medication on Campus: ____

Non-medical staff trained to administer the medication/services: ________________________________

Signature of Authorized Representative: _______________________________________ Date: _________

Address of Authorized Representative: ____

Home Telephone Number: ______________________ Work Telephone Number: _____________________