Authorization for School Personnel to Administer a Non- Prescription Medication to a Minor Child at School

Student's Name: _____ Date:_____

Date of Birth:_____ Grade:_____ Homeroom Teacher:_____

I,_____, Parent/Legal Guardian of the above named student, hereby grant authorization to CCA personnel to administer the following medication to this student while in school, at a school sponsored activity, while under supervision of school personnel, and while in before-school and after-school care.

Name of Medication:_____

Dose of Medication to be given:_____

Time(s) to be administered (Circle all that apply): *As Needed* / _____*am* / _____*pm*

Dates to be given:_____

(Not to exceed two weeks without a Physician's Order)

Condition/Illness Requiring Medication:_____

Possible Side Effects of Medication:_____

I understand that:

- ☐ Creekside Christian Academy and its personnel/agents shall incur NO liability for any adverse effects the student may experience due to the accurate administration of medication.
- ☐ Medications MUST be in their original containers with visible expiration dates.
- ☐ It is the parents/guardians responsibility to inform the school of any changes to current medications and/or doses.
- ☐ A separate form must be completed for each medication sent in.
- ☐ ALL MEDICATIONS WILL BE TAKEN DIRECTLY TO THE FRONT DESK/NURSES OFFICE BY THE PARENT. Students are not allowed to carry medications in their book bags.
- ☐ Unused and/or expired medications will be disposed of, unless picked-up by the parent/guardian, within one week after medication is discontinued or at the end of the school year.

I understand and agree to the conditions of Creekside Christian Academy's Policies. I hereby authorize Creekside Christian Academy and its personnel to assist my child in taking this non-prescribed medication and I release Creekside Christian Academy and any of its personnel/agents of any legal responsibility related to the administration of above named medication. I authorize the school to seek emergency medical treatment for the student when deemed necessary and appropriate.

_____ _____

Parent/Legal Guardian Signature **Date**

(FOR SCHOOL OFFICIAL USE ONLY)

Date:	Time Given:	Amount:	Administered By: