Authorization for School Personnel to Administer a 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. The school has a full understanding of the proper use and administration of these medications.

- ☐ Asthma Inhaler (*Physician Signed Action Plan Required*)
- ☐ Epi-Pen Injector (*Physician Signed Action Plan Required*)
- ☐ Seizure Medication (*Physician Signed Action Plan Required*)
- ☐ Diabetic Medication (*Physician Signed Action Plan Required*)
- ☐ ADHD/ADD Medication
- ☐ Migraine Specific Medication
- ☐ Other Prescribed Medication for a Diagnosed Medical Condition

Name of Medication:_____

Prescription #:_____ **Dose:**_____

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

Condition/Illness Requiring Medication:_____

If an Anaphylactic Allergy List all known Allergens:_____

Possible Side Effects of Medication:_____

If Applicable, Stop Medication on: _____

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 the Rx label still attached.
- ☐ When necessary, specific medications must be accompanied by a Physician signed Action Plan.
- ☐ 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, or any new 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 prescribed medications 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 Office Use Only:
Received by:

_____ _____

Nurse/Principal/Designees Signature **Date**