Authorization for Self-Administration of Medication by a Minor Child at School

A physician's signature must be provided with this documentation

Student's Name: _____ Date:_____

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

I,_____, Parent/Legal Guardian of the above named student hereby request authorization for possession and self-administration of the following medication type:

- ☐ Asthma Inhalers
- ☐ Epi-Pen Injectors
- ☐ Seizure Medications
- ☐ Diabetic Medications

By 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 on school operated property. The student demonstrates full understanding of the proper use/possession of their medications.

I understand that:

- ☐ Creekside Christian Academy and its personnel/agents shall incur NO liability for:
  a.) any adverse effects the student may experience from the self-administration of their medication.
  b.) the student's use, misuse, overuse, or neglected or failed use of their medication;
  c.) lost, misplaced, outdated, inaccessible, empty, or faulty medications and devices;
  d.) the student's misconduct in sharing, selling, or distributing their medication for recreational purposes to any other persons on school property.
- ☐ Creekside Christian Academy has the ultimate authority to enforce rules and consequences for inappropriate behavior demonstrated by the student in association with the possession of and/or self-administration of medication and that the School has the authority to require supervision of medication use as deemed necessary for the safety of all students and staff.

I take sole responsibility for:

- ☐ The monitoring of medications, medication use, and refilling of prescriptions for medications as the school will not be responsible for the supervising, recording, and monitoring of self-administered medications.
- ☐ Ensuring the student always carries their medication on their person.
- ☐ Deciding if back-up medications will be kept at the school and providing the school with those medications and required documentation as outlined in CCA's Policies & Procedures.
- ☐ Informing school staff in writing of any medication side effects that warrant communication from school staff to the parents/guardians.

I understand and agree to the conditions of Creekside Christian Academy's Policies. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given or taken by a person other than the above named student. I release Creekside Christian Academy and its employees and agents of any legal responsibility related to the above named student's possession and self-administration of their medication.

_____ _____

Parent/Legal Guardian Signature **Date**

I, _____, the above-named student has been instructed in the proper use/possession of my prescribed medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student/person to use my medication under any circumstance. I understand and agree to the terms of the school policy.

_____ _____

Student's Signature **Date**

The above named student has been instructed and demonstrates understanding of the proper use of their medication. It is my professional opinion that the student be permitted to carry and/or self-administer their medication.

_____ _____

Physician's Signature **Date**

For Office Use Only:
Received by:

_____ _____

Nurse/Principal/Designees Signature **Date**