CHAMPIONS CHRISTIAN ACADEMY

AUTHORIZATION FOR SELF-ADMINISTERED MEDICATION

Student Name (print) Date of Birth

Known Medication Allergies

Parent/Legal Guardian Daytime Phone Number(s)

Emergency Contact Daytime Phone Number(s)

I request that my child be allowed to carry the below listed medication as ordered by his/her physician.

- I have fully instructed my child on the proper administration of this medication and it is my opinion that he/she does not need adult supervision of medication administration.
- I accept full responsibility for the appropriate use of the medication in regard to my child.
- I am aware of the risks to my child and to other children and assume responsibility for any liability related to the use or misuse of the medication by my child or by other children.

Furthermore, I consent and authorize the Champions Christian Academy nurse to communicate with the prescribing physician regarding my child's health condition and/or medication order as needed. This consent will remain in effect for the duration of the medication order.

Parent/Legal Guardian Signature Date

TO BE COMPLETED BY AUTHORIZING PHYSICIAN, P.A., OR NURSE PRACTICIONER

Medication: _____ Dosage (amount to be given): _____

Form of medication: _____ Route of administration: _____
(tablet, capsule, liquid, injection, etc.)

- This student must carry the above mentioned medication with him/her at all times during the school day for the following reason:
  _____
  _____
- I have instructed the student in the proper administration of this medication and it is my professional opinion that he/she needs no adult supervision of medication administration.
- I have further instructed the student in the dangers of giving this medication to anyone other than himself/herself.
- I have discussed the above stated risks and liabilities with the parent.

Physician Signature Date

Physician Name (print) Phone Number Fax Number

School Office Use
Date Completed Form on File: _____ *CCA Nurse Signature:* _____