



Prescription Medication Administration Authorization

Medications at school are administered following these guidelines:

- **Physician signed and dated authorization to administer the medication.**
- **Parent signed and dated authorization to administer the medication.**
- **Medication is in the original labeled container as dispensed, or the manufacturer's labeled container.**
- **The medication label contains the student name, date, name of medication, and directions for use.**
- **Annual renewal of authorization and immediate notification, in writing, of changes.**

Student's Name _____ Grade _____ Birthdate _____

Medication to be administered _____

Dosage _____ Time Interval _____

Reason for medication _____

Date to begin administration _____ Date to end administration _____

Side effects of this medication _____

Name of authorizing physician _____ Phone _____

Other Medications Student is taking _____

Signature of Physician _____ Date _____

I request that the school (Cornerstone Christian Academy of McLean County Inc.) administer the above medication to my child in accordance with the prescribing physician's authorization. I agree to notify the school in writing of any changes in my child's condition with respect to the administration of medication or with any changes to the information provided on this form. The school agrees to keep a written log of medications given to my child in school.

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Cornerstone Christian Academy of McLean County Inc. and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer while under the supervision of the employees and agents of Cornerstone Christian Academy), lawfully prescribed medication in the manner above. I acknowledge that it may be necessary for the administration of medications to my child be performed by an individual other than a nurse, and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the school, its employees and agents arising out of the administration of said medication. In addition I agree to hold harmless and indemnify Cornerstone Christian Academy of McLean County Inc., its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from administration or attempts at administration of said medication.

Parent name: _____ Daytime Phone _____

Parent Signature: _____ Date _____

Parent Address _____ Alternate Phone _____