Cornerstone Christian Academy
Medication Authorization Form

Student Name: ____ Date of Birth: _______________________
(Last, First, Middle Initial)

As the parent/guardian, I understand that it is the policy of Cornerstone Christian Academy that as a regular and normal practice, medication should not be administered to a student at school or when such student is involved in school activities. However, in order to provide for the critical health and well-being of students, medication may be administered during school hours by a certified school nurse, a registered nurse, administrative personnel, administrative designee, or self-administered by a student. I further release my child's school and individual members thereof, and its employees shall be indemnified and held harmless from any and all claims arising out of the administration of said medication.

Medication must be brought to the school in the original container, labeled appropriately by the pharmacist or licensed prescriber.

I request that my child be assisted in taking the medication described below at school by authorized persons or be permitted to medicate herself/himself as also authorized by me and my physician (below). I have administered this medication to my child previously and am aware of potential side effects. I further consent to the sharing of relevant medical information between the school and the physician's office.

____

Date **Parent/Guardian Signature** **Home Phone** **Emergency Phone**

For parent(s)/guardian(s) of students who need to carry asthma medication, diabetes medication, or an epinephrine auto-injector:
I authorize Cornerstone Christian Academy and its employees and agents to allow my child to ward or possess and use his or her asthma medication, diabetes medication, and/or epinephrine auto-injector while in school, at a school-sponsored activity, under the supervision of school personnel, or before or after normal school activities such as while in before-school or after-school care on school-operated property. Illinois law requires the school to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication (105 ILCS 5/22-30).

If you agree please initial: __________

PRINTED PHYSICIAN'S NAME:	
PHYSICIAN'S ADDRESS:	**PHONE:**
Medication Name:	
Purpose of Medication/Diagnosis:	
Route:	
Dose:	
Frequency/Time of Administration:	
If medicine is to be given "as needed" describe the indication:	
How soon can the dose be repeated?	
Is child authorized to medicate herself/himself?	
List significant side effects:	
Length of time this treatment is recommended:	
Must this medication be administered during the school day in order for the child to attend school or to address the child's medical condition that may arise at school?	YES NO

____

Date Physician Signature **Only**

School Nurse Initials __________