PARENT/GUARDIAN AUTHORIZATION, WAIVER, AND CONSENT FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Student Name: _____

Event Name: _____ **Event Date:** _____

This portion of the form must be completed fully in order for the Event participants to self-administer required medication. A new medication administration form must be completed for each Event attended. Self-medication requires both a licensed health care authorization & signature, ***and*** parent signature.

_____ No, my child does not need to take any prescription medication while at the Event.

_____ Yes, my child will need to take prescription medication while at the Event.

All prescription medications, including medications for conditions such as food, drug, insect allergies, diabetes, asthma, or epilepsy, may be brought to the Event under the condition that the student can self-manage the care and delivery of the medication with written authorization by a licensed health care provider. Prescription medication must be in its original container labeled by the pharmacist or prescriber. The label must include the name, address, and phone number for pharmacist or prescriber. Containers must hold only the amount required for the time the student will be attending the Event.

PRESCRIBER AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIPTION MEDICATION

Medication Name: _____ Dose: _____

Condition for which medication is being administered: _____

Specific Directions (e.g., on empty stomach/with water, etc.): _____

Time/frequency of administration: _____

If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: _____

Medication shall be administered from (date): _____ to: _____

Special Storage Requirements: _____

Is the student capable of self-managed care? _____ YES _____ NO

Prescriber's Name/Title: _____ Prescriber's Place of Employment:_____

Prescriber's Phone:_____ Prescriber's Fax :_____

I hereby affirm that this individual has been instructed in the proper self-administration of the prescribed medication(s).

Prescriber's Signature: _____ **Date:** _____

I waive and release Crossroads Fellowship Church, its agents, representatives, and employees from any and all liability or responsibility for the administration of the prescription or benefits or consequences of the prescribed medication and acknowledge that the church bears no responsibility for ensuring that the prescribed medication is taken. With regard to medication retained and self-administered by the student, I further waive and release the church, its agents, representatives and employees from any and all liability, acknowledge that the student is solely responsible for maintaining possession of the medication, taking the medication according to the prescribed instructions, and properly securing the medication to guard against any other individual improperly gaining access to the medication.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date