

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

**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 an 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