



Christian Liberty Academy

502 W. Euclid Avenue, Arlington Heights, Illinois 60004
(847) 259-4444 FAX (847) 259-9972



MEDICATION ADMINISTRATION AUTHORIZATION FORM

I hereby request and grant permission for Christian Liberty Academy school personnel to administer or supervise the self-administration of the above-indicated medication to my daughter/son, _____, ACCORDING TO THE HEALTH CARE PROVIDER'S SIGNED INSTRUCTIONS ON THE LOWER PART OF THIS FORM. I understand that an individual other than the school nurse may perform this administration or supervision, and I specifically consent to this. I further waive any claims against Christian Liberty Academy, members of the School Board, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorneys' fees, resulting from or arising out to the administration of medication. Christian Liberty Academy agrees to administer medication prescribed by a licensed health care provider.

It is the parent/guardian's responsibility to furnish the medication. The parent/guardian agrees to pick up expired or unused medication within one week of notification by staff, or the medication will be discarded.

Prescription Medications must come in a container labeled with: Child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label. Over-the-counter medication must be labeled with child's name. Dosage must match the signed health care provider's authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

Parent/Legal Guardian's Name

Parent/Legal Guardian Signature

Dated

Health Care Provider Authorization to Administer Medication in School

Child's Name: _____ Date of Birth: _____

Medication: _____

Dosage: _____

Route of Administration: _____

Time(s) to be given: _____

Purpose of Medication: _____

Possible side effects requiring notification: _____

Starting Date: _____ Ending Date: _____

Signature of Health Care Provider with Prescriptive Authority

License Number of Health Care Provider

Printed Name of Health Care Provider

Phone Number

Dated: _____

PLEASE ASK PHARMACIST FOR A SEPARATE BOTTLE/CONTAINER TO KEEP AT SCHOOL.