

CROSSROADS

CHRISTIAN SCHOOL

MEDICAL RELEASE FORM

AUTHORIZATION FOR SCHOOL STAFF TO ADMINISTER MEDICATIONS RELEASE AND INDEMNIFICATION AGREEMENT

Crossroads Christian School discourages the administration of medication to students in school during the school day. Any necessary medication that possibly can be administered before or after school should be. School personnel will, when it is absolutely necessary, administer medication to students during the school day and while participating in outdoor education programs and field trips, according to the procedures outlined on page 2 of this form. Please do not use abbreviations.

*****A SEPARATE FORM REQUIRED FOR EACH PRESCRIPTION OR OTC MEDICATION*****

Part I – To Be Completed by the Parent/Guardian

I hereby request and authorize the school personnel to administer Over The Counter (OTC) medication as directed below. I agree to release, indemnify, and hold harmless the school and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering OTC medication to this student. **I have read the procedures outlined on page 2 of this form and assume the responsibilities as required.**

Student's Name: _____ Birth Date: _____ Grade: _____

Address: _____

Emergency Contact: _____ Phone: _____

Medication Name: _____ Diagnosis (write out): _____

Dosage: _____ Frequency (write out): _____ Time(s) to be given at school: _____

Part II – To Be Completed by the Prescribing Physician

I hereby request and authorize the school personnel to administer prescribed and/or Over The Counter (OTC) medication as directed by the physician. I agree to release, indemnify, and hold harmless the school and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering prescribed medication to this student, provided the school staff are following the physician's order as written below. **I have read the procedures outlined on page 2 of this form and assume the responsibilities as required.**

Physician's printed name: _____ Office Phone: _____

Office Address: _____

Medication Name: _____ Dosage: _____ Frequency: _____

Times to be administered/under what circumstances: _____

Purpose: _____ Diagnosis requiring medication: _____

Is it necessary for this medication to be administered during the school day? Yes No

Expected side effects, if any: _____

Other medications student is receiving: _____

Physician's signature

Date

Part III – To Be Completed By the School Staff

- Parts I and II above are completed, including signatures. Medication is properly labeled by pharmacist.
 Medication label and physician order are consistent. OTC Medication is in manufacturer labeled container.

School Staff Signature/Date _____

(Parents must complete back of form)

INFORMATION AND PROCEDURES

1. No medication will be administered in school or during school-sponsored activities without the parent's/guardian's written authorization and a written physician order. This includes both prescription and over-the-counter (OTC) medications.
2. The parent/guardian is responsible for completing the **CCS Medical Release Form**. This is required every school year for each new or continuing order or if there is a change in dosage or time of administration during the school year. (A physician may use office stationery or prescription pad in lieu of completing Part II but must include child's name, diagnosis, medication name, dosage, time of administration, duration of medication, side effects, physician signature, and date.)
3. **The medication must be delivered to the school by the parent/guardian** or, under special circumstances, an adult designated by the parent/guardian. Under no circumstances will CCS administer medication brought to school by a child.
4. All prescription medication must be provided in a container with the pharmacist's label attached. OTC medication must be in the container with the manufacturer's original label. Physician samples must be appropriately labeled by the physician.
5. **The first day's dosage of any new medication must have been given at home before it can be administered at school.**
6. The parent/guardian is responsible for collecting any unused medication within one week after expiration of the physician's order or at the end of the school year. Medication not claimed within that time period will be destroyed.
7. Self-administered and/or non-medically prescribed medications are entirely the responsibility of the parent/guardian and not that of Crossroads Christian School.
8. Students may not self-administer controlled substances.
9. A physician's order and parental permission are necessary for self-carry/self-administered emergency medications such as inhalers for asthma and EpiPens® for anaphylaxis. The school must evaluate and approve the student's ability and capability to self-administer medication. It is imperative the student understands the necessity for reporting to teacher or other school staff that they have self-administered their inhaler without any improvement or have self-administered an EpiPen®, so that 911 may be called.
10. The school staff will call the prescriber if a question arises about the child and/or the child's medication.
11. This form is effective for the current school year.

I have read the above parent/guardian information and assume the responsibilities as required

For only parents/guardians of students who need to carry asthma or diabetes medication or an EpiPen®:

I authorize the CCS and its employees and agents, to allow my child or ward to possess and use his or her asthma or diabetes medication and/or epinephrine auto-injector: (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school on school-operated property. This agreement stands to inform parent(s)/guardian(s) that Crossroads Christian School employees and agents, incur no liability, as a result of any injury arising from a student's self-administration of medication or epinephrine auto-injector. ***If you agree, please initial:*** _____

For all parents/guardians:

By signing below, I agree 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 the CCS and its employees and agents, in my behalf, 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 the school), lawfully prescribed medication in the manner described above. **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school staff and specifically consent to such practices**, and I agree to indemnify and hold harmless Crossroads Christian School and its employees and agents against any claims arising out of the administration or the child's self-administration of medication.

Parent/Guardian printed name

Parent/Guardian printed name

Parent/Guardian signature

Date

Parent/Guardian signature

Date