**NORTHPOINT CHRISTIAN SCHOOL**
Medication Authorization for Self-Administration

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|---|---|---|
| Student Name: | Date of Birth: | |
| School: | Grade: | |
| Mother's Name: | Phone Hm: | Work/Cell: |
| Father's Name: | Phone Hm: | Work/Cell: |
| Physician's Name: | Phone | |

_____ This student may carry and self-administer the following medications at school.

_____ This student may carry the following medication for administration BY school personnel.

Name of medication: _____

Dosage: _____ Time: _____

Start Date: _____ End Date: _____

Symptoms that may indicate need for medication:
_____

_____

Factors that may trigger/precipitate symptoms:
_____

_____

Specific instructions if student has symptoms:
_____

_____

**PHYSICIAN APPROVAL**
I agree with the above medication plan, including the name, purpose, dosage and administration directions of the medication.

It is my professional opinion that this student should be permitted to carry and self-administer this medication.

_____
Physician Signature Date

**PARENTAL CONSENT & RESPONSIBILITIES**

I, the parent/guardian of the above named child, understand and agree to the conditions of the school policy on medication administration. I permit the school to seek emergency medical treatment for my child when deemed necessary and appropriate. I give authorization for self-administration and possession of the named medication by my child while at school, at school-sponsored activities, while under the supervision of school personnel and while in before- or after-school care on the school property. My child demonstrates a full understanding of the proper use of this medication.

I am responsible for: (1) Monitoring the medication, medication use, and supplying the medication..
(2) Ensuring my child always carries this medication on his/her person. (3) Deciding if back-up medication will be kept at school, and providing the school with back-up medication. (4) Informing the school in writing of any changes in treatment or medical condition of my child. (5) Informing the school of any medication side effects of which I should be notified.

I consent for the physician to release information about my child related to this medication to the school nurse.

I release Northpoint Christian School and its employees of any legal responsibility related to my child's possession and self-administration of this medication.

_____
Parent/Guardian Signature Date

**STUDENT AGREEMENT:** I understand and agree to follow the Northpoint Christian School's policy for self-administration of my medication while at school. I have been instructed in the proper use of this medication. I will be responsible for carrying the medication and will not allow another student to use my medication under any circumstances.

_____
Student Signature Date