PIKE COUNTY CHRISTIAN ACADEMY

Prescription Medication Authorization Form

Student Name: _____ Birthdate: _____ Grade: _____

TO BE COMPLETED BY PHYSICIAN **All medication requires annual authorization.**

Name of Medication	Dosage	Frequency	Time	Intended effect/Expected Side effect, if any If epi pen or inhaler allowed to carry?

Physician's Signature	**Date:**
Physician's Name(print)	
Address/Phone	

I confirm that I am primarily responsible for administering medication to my child, however, in the event that I am unavailable to do so or in the event of a medical emergency, I hereby authorize PCCA and its employees and agents, in my behalf and stead, to administer or attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of PCCA), 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 nurse, and specifically consent to such practices.** I further acknowledge and agree that, when the lawfully prescribed medication is administered or attempted to be administered, I waive any claims I might have against the school, its employees and agents arising out of administration of said medication. I agree to hold harmless and indemnify the school, its employees and agents, either jointly or severally, from and against all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts of administration of said medication.

Parent/Guardian Signature: _____Date:_____

Parent/Guardian Name (Print): _____