



**Permission To Self-Administer Prescribed Medication**  
(Confidential)

South Elkhorn Christian Church  
4343 Harrodsburg Road  
Lexington, KY 40513  
859-223-1433

**Parent or Legal Guardian Authorization for Self-Administration/Self-Possession of Medication**  
*Waiver and Release of All Claims*

South Elkhorn Christian Church will only allow the self-administration/self-possession of medication by a minor child when the permission to Self-Administer Prescribed medication Form has been fully completed by a parent/legal guardian. South Elkhorn Christian Church’s internal procedures on dispensing medication are available for review.

**PLEASE NOTE THAT THIS FORM IS VALID FOR THE ENTIRE PROGRAM YEAR – AUGUST THROUGH JULY.  
IT IS THE PARENT’S OR LEGAL GUARDIAN’S RESONSIBILITY TO NOTIFY THE CHURCH OF  
ANY CHANGES THAT NEED TO BE MADE DURING THE PROGRAM YEAR.**

**PROGRAM YEAR: 2016-17**

*Self-administration means that the minor may administer the medication in a manner directed by the physician without additional direction or supervision by South Elkhorn Christian Church’s staff/leaders. Self-possession means that under the direction of the physician, the minor may carry medication on his or her person to allow for immediate and self-determined administration. For medication other than inhalers, only that day’s supply of medication is to be carried. South Elkhorn Christian Church recommends that spare medication, properly labeled in its original container, be kept with the program/event leader in case the child runs out/forgets the medication. The leadership of South Elkhorn may discontinue the child’s self-administration privilege upon advance notice to the parent/legal guardian.*

**To be completed by parent/guardian:**

I request and give permission for (name of child) \_\_\_\_\_ to self-administer the prescribed medication(s)/treatment listed on the reverse side of this form during South Elkhorn Christian Church sponsored events according to South Elkhorn Christian Church policy and for the physician(s)/staff and church leadership/staff to share information needed to assist my child with medication needs.

- I understand it is my responsibility to give the spare or additional days of the listed medication directly to the program staff in original prescription containers clearly labeled with my child’s name and the dispensing information as indicated on the reverse side of this form.
- In all cases, the recommended dosage of any medication is not to be exceeded. If, after self-administering medication, there is an adverse reaction, I give my permission to South Elkhorn Christian Church to secure from any licensed hospital physician and/or medical personnel any and all medical services necessary.
- I recognize and acknowledge that there are certain risks of physical injury in connection with the self-administering of medication by my minor child. In consideration of South Elkhorn Christian Church’s permission for the self-administration of medication by my minor child, I do hereby fully release or discharge South Elkhorn Christian Church, and its officers, agents, volunteers, and employees from any and all claims from injuries, damages and losses I or my minor child may have, arising out of, connected with, incidental to, or in any way associated with the self-administering of medication. I further agree to indemnify, hold harmless, and defend South Elkhorn Christian Church, and its officers, agents, volunteers, and employees from any and all claims resulting from injuries, damages and losses sustained by me or my minor child arising out of, connected with, incidental to, or in any way associated with the self-administering of medication.
- In all cases, self-administration of prescribed medication can only be changed or modified by completing another Permission To Self-Administer Prescribed Medication Form.

\_\_\_\_\_  
Parent signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent phone number

(OVER)

**MEDICATION INFORMATION FOR SELF-ADMINISTRATION**

**THIS FORM MUST BE COMPLETED FOR EACH PROGRAM YEAR OR WHEN MEDICATION NEEDS CHANGE**

**BACKGROUND INFORMATION** (Please print):

Minor Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**MEDICATION INFORMATION:**

**Medication Name:** \_\_\_\_\_ **Dose:** \_\_\_\_\_ **Time:** \_\_\_\_\_

Dispensing & Storage Instructions:  
\_\_\_\_\_  
\_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

**Medication Name:** \_\_\_\_\_ **Dose:** \_\_\_\_\_ **Time:** \_\_\_\_\_

Dispensing & Storage Instructions:  
\_\_\_\_\_  
\_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

**Medication Name:** \_\_\_\_\_ **Dose:** \_\_\_\_\_ **Time:** \_\_\_\_\_

Dispensing & Storage Instructions:  
\_\_\_\_\_  
\_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

**OTHER INFORMATION:**

\_\_\_\_\_  
\_\_\_\_\_

I understand it is my responsibility to give the spare or additional days of listed medication directly to the program leaders in original prescription containers clearly labeled with my child's name and the dispensing information as indicated above.

In all cases, self-administration of medication can only be changed or modified by completing another Permission to Self-Administer Prescribed Medication Form and Medication Information Form.

I hereby acknowledge that the above information provided for the self-administration of prescribed medication by my minor child is accurate.

X \_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date