



Medication Permission Form

Medication must be delivered in the original packaging or pharmacy labeled container. Prescription drug labels must include the student's name, name of the drug, dose, method of administration, the interval between doses, and name of the provider authorizing the medication.

The medication must be delivered by the parent to the school nurse, or Crossroads office manager. Medications should not be carried in student's backpacks/pockets. This is of particular importance if the medication is a prescription drug since many of these drugs are controlled substances.

Please pick up any remaining medication within ten days of discontinuation or at the end of the school year for long term meds. A new prescription container will be required in the fall.

I request that my child _____ receive the following medication at school:
(child's name)

| Drug Name | Dose/Route | Time of Day |
|-----------|------------|-------------|
|-----------|------------|-------------|

Dates and duration of medication treatment _____

Reason for medication: _____

Other Medications my child is taking: _____
(Medication names and doses)

A physician's signature is required for all prescription medications in school.

Physician's Signature _____ Date _____

*A signed prescription or letter from your physician is also acceptable

I authorize the Crossroads Academy school nurse, or a designee of the school nurse to assist my child in taking the above stated medication during school hours. I agree that I will not hold liable these members of the Crossroads Academy staff for harm or injury resulting from the administration or assistance in the administration of this medication.

Parent Signature _____ Date _____