Crossroads Academy Prescription Medication Permission Form

Please complete this form if your student has daily prescription medications that will be administered during school hours OR as-needed or emergency use prescription medications that will be kept at the school for use. Either have the student's health care provider/prescriber sign this form or include an order form for the medication.

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

The medication must be delivered by the parent to the school nurse or Crossroads Academy office manager. Medications should not be carried in student's backpacks/pockets unless approved by the parent and school nurse. This is of particular importance if the medication is a prescription medication.

At the end of the school year, the school nurse will package the remaining medication and arrange for parent pick up.

I request that my child, _____
receive the following medication at school:

_____ _____ _____

Medication Name **Dose/Route** **Time of Day**

For short-term medications such as antibiotics, list dates and duration of treatment:

_____

Reason for medication:_____

Other Medications my child is taking:_____

_____

_____

A physician's signature is required for all prescription medications in school. Either have this form signed or include the provider's signed medication order form.

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:**_____

Parent Name:_____