



CROSSROADS CHRISTIAN SCHOOL

Consent to Administer Prescription Medication During School Hours

This section is to be completed by student's physician:

Name of Student _____

Medication _____ Dosage _____

_____ Check if student needs to carry/use medication at school.

Time(s) medication is to be given: _____ AM _____ PM

Dates to be given (Valid one school year) _____ to _____

Significant Information (include side effects, toxic reactions, omission reaction):

Contradictions for Administration: _____

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to: (Check all that apply.)

Contact me at my office _____
Physician Name and phone number

Take child immediately to the emergency room at _____

Call 911

Other option _____

This medication will be furnished by the parent or guardian within a container properly labeled by a pharmacist with identifying information, (e.g. name of child, medication dispensed, dosage prescribed, and the time it is to be given).

Physician Name (print) Physician Signature & DEA# Date

Parent's Permission

I hereby give my permission for my child named above to receive and/or carry/use medication during school hours. This medication has to be prescribed by a licensed physician. I hereby release Crossroads Christian School and its agents and employees from all liability that may result from my child taking the prescribed medication. I also authorize my child's medical provider to release information to the school nurse that is deemed necessary for the administration of medications at school in accordance with the Health Insurance Portability and Accountability Act of 1996.

Parent Signature Telephone Number Date

Emergency Contact Name Telephone Number Date