

Crossway Academy



PHYSICIAN'S SCHOOL MEDICATION FORM

TO BE COMPLETED BY MEDICAL PROVIDER

Student's Name: _____ Date of Birth: _____

Name of School: _____ Grade: _____

The above named person is a patient currently under my medical care. Due to a medical condition the medication listed below must be (given/taken/injected) during regular school hours according to the following protocol:

Medication: _____ Dose: _____ Route: _____

Dose must be exact; ranges will not be accepted.

Routine/Daily Medications: exact time to be given _____ a.m. _____ p.m.

As needed (p.r.n.) medication for: _____ give every _____ hour(s).

Directions for administering medication: _____

Please indicate any special storage requirements such as room temperature, refrigeration, etc. _____

Physician's Signature: _____ Date: _____

MD Stamp Below

Physician's Printed Name: _____

Office Phone: _____ FAX: _____

Office Address: _____

City, State, ZIP: _____

This order will expire one year from the date the physician signed.

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I understand that:

- prescription medications may be administered at school and must be in a pharmacy-labeled prescription bottle that matches the C A Physician's School Medication Form. Medication dosage, time and intervals, must be exact.
- the school nurse is available one day a week.
- non-medical personnel administer medications daily.
- prior to school administration, the parent/guardian is required to sign the check-in/check-out log for medication.
- students are not permitted to transport medication to or from school.
- medication may only be administered as ordered on the approved C A medication forms.
- if medication is not available at the school, 911 will be called for emergencies.
- the parent/guardian is responsible for notifying coaches or supervising staff of before and/or after-school activities of the child's health status and/or the need for medication.
- I may contact the Primary Medication Clerk or school nurse if assistance is needed to ensure medication meets CA Protocol for Medication Administration.
- **medication not picked up within two weeks of the last day of school will be discarded.**

RELEASE OF LIABILITY FORM

I, _____, the parent/legal guardian of _____ enrolled at Crossway Academy, realizing the importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel and Crossway Academy/Therapy of and from any liability from any potential ill effects as a result of their injecting or giving my child medication prescribed by the child's physician. I consent for the medical provider to disclose health and medical information regarding the medication prescribed. This consent is valid until I revoke it in writing or for the term of one year.

Parent/Legal Guardian's Signature: _____ Date: _____

Principal's Signature: _____ Date: _____

FOR OFFICE USE ONLY: This order will expire one year from the date the physician signed. This form will expire on _____
DISPOSITION OF MEDICATION: Date medication was picked up _____ or date medication was discarded _____
by Staff Name: _____ Staff Signature: _____ Witness: _____