Crucifixion School
420 South Second Street
La Crescent, MN 55947
www.crucifixionschool.org
Phone: (507) 895-4402

# Medication Administration and Parent Authorization Form

Student information:

NAME: ______________________________________________

BIRTHDATE: ______________________ GRADE: _____________

MEDICATION: ______________________ DOSE: _____________

ADMINISTRATION DATES: _______________ TIME: _____________

INDICATION TO ADMINISTER ___________________________________

(example: pain, headache, ADHD, infection, etc.)

PARENT CONSENT:

1. I request the above medication be given during school hours.
2. I will notify the school of any change in medication.
3. I release the school from any liability in relation to this request when the medication is given as ordered.
4. Medication will be supplied in its original and properly labeled container.
5. I give the school permission to communicate information to staff about the medication and/or side effects.

Parent Signature: ___________________________________________

Date: _____________________ Phone number: _______________________

Physician Order:

* Only required for prescription medications. May have order faxed to 507-895-6880.

Physician Signature: ___________________________________________

Date: _____________________ Phone number: _______________________

*"Learning to Grow, Love and Live Within a Christian Community"*