Crosspointe Christian Academy

Medication Administration Authorization Form

Student Information

Student Name:

Date of Birth: Grade: Teacher:

Medication Information

Name of Medication: Dosage:

Time(s) to be Administered: Refrigeration Required: Yes No

Reason for Medication:

Special Instructions:

Parent/Guardian Authorization

I hereby authorize Crosspointe Christian Academy staff to administer the above medication to my child as prescribed. I understand that:

- Medication must be provided in its original, labeled container.
- A new form must be completed if the medication or dosage changes.
- All medications must be delivered to the school by a parent/guardian.

Signature of Parent/Guardian:_____

Date:_____ Phone Number:_____

Physician's Authorization (Required for Prescription Medications)

Physician Name:

Phone:

Address:

Signature:_____ Date:_____