CROSSINGS
CHRISTIAN SCHOOL

Physician Statement of Need for Medication

Student's Name: _____

Grade: _____ DOB: _____

Address: _____

Parent's Name: _____

Home Phone: _____ Parent cell phone: _____

Medication to be administered: _____

Generic name (if applicable): _____

Dosage to be administered: _____

Time or interval at which each dosage is to be administered: _____

Date to begin: _____ Date to cease: _____

Possible adverse reactions: _____

List severe reactions that should be reported to parent/physician: _____

_____

Instructions for medication storage:

_____

Physician's name: _____

Physician phone number: _____

Physician address: _____

Emergency contact information for physician: _____

Physician's signature _____

Date: _____

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Release and Authorization for Medication Administration

The undersigned, as the parents, guardians and/or legal representatives of _____ _____ ("child"), hereby agree to the following:

1. The undersigned hereby authorize representatives of Crossings Christian School ("CCS") to administer _____ (medication) to _____ ("child") as set forth in the attached **Physician Statement of Need for Medication**.

2. The undersigned hereby releases and forever discharges CCS as well as its agents, insurance companies, insurers, attorney, employees, teachers, representatives, administrators, board members, volunteers, staff and any related and/or affiliated party or individual of CCS from any and all liabilities, claims, cause of actions, costs or damages arising out of or related to the administration and/or the failure to administer medication to the child. The undersigned hereby covenants not to pursue any such claims.

3. The undersigned hereby understands and acknowledges all risks associated with the providing of medication and/or the failure to provide medication to the child and is aware of the potential of harm that could result to the child by way of this authorization.

4. Any and all disputes between the parties to this agreement and/or arising out of or relating to the providing of medication or the failure to provide medication to the child shall be settled by arbitration pursuant to the rules and regulations of the American Arbitration Association. Arbitration shall be undertaken pursuant to the Federal Arbitration Act and shall be held in Oklahoma City, Oklahoma. Each party shall bear its own costs and attorney fees arising out of or related to the arbitration.

5. I further agree to notify CCS in writing of any changes to the child's condition with respect to the administration of such medication or of any changes to the information set forth in the Physician Statement of Need for Medication. I also agree to provide medication in its original container:

Dated this _____ date of _____, 20____

_____
Signature of Parent or Guardian

Home phone: _____

Business phone: _____

Cell phone: _____

_____
Signature of 2nd Parent or Guardian

Home phone: _____

Business phone: _____

Cell Phone: _____