CROSSROADS EARLY LEARNING CENTER
114 OLD STAGE ROAD
EAST BRUNSWICK, NJ 08816
732.251.3221
Fax 732.723.9026

MEDICATION FORM

Dear Physician:
Please fill out this **Medication Form** so that we have detailed instructions on the administration of medication to the child by our staff. Be sure to **return this form to the parent, along with the prescription, prior to leaving your office today.** This will ensure that the child is given the medicine promptly upon returning to school.

Thank you,

Vivian Munro, Director

For Use during the _____School Year and Summer Program:

Child's Name: _____ **Date:** _____

Diagnosis: _____

Name of Medication: _____

Dosage: _____

Schedule: _____

Period of Time: _____**Days** _____**Other**

_____**Weeks**

_____
Signature of Physician

_____
Address

_____
Phone

I hereby give permission to School Personnel to administer medication to my child as directed above by the physician. I release school personnel of all liability.

_____ _____
Parent Signature **Date**