

Valley Christian Academy
**2009-2010 PHYSICIAN AND PARENT REQUEST
FOR THE ADMINISTRATION OF MEDICATION**
by School Personnel

Student _____

Address _____

City / State / Zip _____

Name of Medication and Dosage _____

Times of Day to be Administered _____

Number of Times/Intervals Medication is to be Administered _____

Date to Begin Medication _____ Date to End Medication _____

This medication can be safely administered by non-medical personnel. Yes No

Is it impossible to arrange for this medication to be taken at home and, therefore, it must be administered during school hours? Yes No

This student is under my care. It is not possible to arrange for this medication to be taken at home under the supervision of a parent and, therefore, it must be taken during school hours.

Physician's Printed Name Telephone

Physician's Signature Date

Please regard my signature below as my assurance that I release Valley Christian Academy, PSI, and any or all of the school's and PSI's officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the time prescribed. I also agree to keep the school informed in writing of any revision in the physician's prescription. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.

Parent's Printed Name Telephone

Parent's Signature Date