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__________________

Adverse/Severe Reaction that Should be Reported to Physician______________________

Special Instructions for Administration of Medication____________________________

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

It is 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 and under the supervision of a parent, and therefore it must be taken during school hours.

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Physician's Printed Name Telephone

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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 times 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.

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Parent's Printed Name Telephone

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Parent's Signature Date

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