



IVYWOOD CLASSICAL ACADEMY

Permission to Administer Medication

This form must be completed and signed by the doctor before any medication may be administered to the student. Medication should be in its original container with child proof cap and labeled. No exceptions will be made.

Students Name: _____ Grade: _____ D.O.B.: _____

Teacher: _____

I hereby request that my child be administered his/her prescribed medication by Ivywood Classical Academy personnel. I understand that the medication will be administered per the physician's order.

Parent/Guardian Signature: _____

Phone Number: _____

PHYSICIAN'S DIRECTIONS TO BE COMPLETED BY THE PHYSICIAN ONLY	
Begin Administering Medication Date: _____	End Administering Medication Date: _____
1. Name of Medication: _____	
Dosage: _____	Frequency: _____ Time to be given: _____
2. Name of Medication: _____	
Dosage: _____	Frequency: _____ Time to be given: _____
3. Name of Medication: _____	
Dosage: _____	Frequency: _____ Time to be given: _____
4. Name of Medication: _____	
Dosage: _____	Frequency: _____ Time to be given: _____
Physician Signature: _____	Date: _____

I _____ authorize Ivywood Classical Academy, through its administrators and/or staff to administer medication or to supervise the taking of medication by my child. I will notify the school of any changes or discontinuation of this medication in writing. Refills are the responsibility of the parent. Further, I release and indemnify Ivywood Classical Academy and its employees from any liability or damage, which may result from the administration of said medication as prescribed by the physician. I understand that I have the right to come in to the school and administer this medication to my child.

Parent/Guardian Signature: _____ Date: _____

Home/Cell Phone: _____ Emergency Phone: _____

Name of Doctor: _____ Doctor's Phone: _____

