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 it's 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 it's** 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 it's 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 mediation to my child.

Parent/Guardian Signature: _____ Date: _____

Home/Cell Phone: _____ Emergency Phone: _____

Name of Doctor: _____ **Doctor's Phone**: _____