Venture Academy
Authorization of School Personnel
to Administer Medications

Name of Student:_____ DOB:_____

Address:_____ Home Phone:_____

Parent/Guardian:_____ Cell Phone:_____

Work Phone:_____

Emergency Contact:_____ Phone:_____

School/Teacher:_____

Name of licensed health care provider completing form: (*Please Print*)

_____

Licensed Health Care Provider's Statement:

1. Name/type of medication:_____
2. Dosage/amount to be given:_____
3. Frequency/times to be administered:_____
4. Duration (week, month, indefinite, etc.):_____
5. Anticipated reactions to medication (symptoms, side effects for underdose/overdose, etc.)

_____

_____

_____

_____

_____ _____

Signature of Licensed Health Care Provider Date

Parent/Guardian Request/Approval

I hereby request and give my permission for the above named student to receive the specified medication as stated in the above instruction from the health care provider. I understand that the school administration will designate specific staff to administer medication, train staff, assure proper identification and safekeeping of medication, and maintain records of such administration of medication.

I further understand that school personnel who provide assistance (administration of specified medication so noted) or employer of such staff are not liable, civilly or criminally, for any adverse reaction suffered by my child as a result of taking the medication so indicated and discontinuing the administration of the medication in keeping with the procedure outlined above.

_____ _____

Signature of Parent/Guardian Date