Request for Medication Administration
2016-2017

(To be completed by parent or guardian.)

Student's Name: _____

Birth Date: ____/____/____ Grade: _____

Parent's Name: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Emergency Contact Information: _____

Phone Number: _____ Cell Phone: _____

Medication to be administered: _____

Date to begin administration: _____

Date to cease administration: _____

Dosage to be administered: _____

Physician authorizing administration: _____

Phone number: _____

I request that TVA administer the above medication to my child in accordance with my request and the physician's statement of need. I agree to notify the school in writing of any changes in my child's condition with respect to the administration of medication or with any changes to the information provided on this form. I understand that it is my responsibility to send an appropriate supply of medication to school in this original container. Medication provided to the school in any container other than the original will not be accepted. I understand that the school will have limited liability while administering medication to my child in accordance with a physician's statement of need. The school agrees to keep a written log of medication administered to my child in school throughout the current year.

_____ _____

Parent Signature Date

Tualatin Valley Academy
A SEVENTH-DAY ADVENTIST SCHOOL

Medication Record
For Office Use ONLY

Name: _____

Instructions: _____

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