LIVINGSTON
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 Livingston 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 Livingston 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 Livingston 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: _____

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Administering Medication Log

Staff Administering Medication Name: _____

Student's Name: _____

Type of Medication	Date	Time	Initials