TREASURE VALLEY CLASSICAL ACADEMY

Administration of Medication/Medical Procedures

(Please complete a separate form for each type of medication or procedure)

Student's Name:_____

Date of Birth: _____ Home/Emergency Phone Number:_____

Address: _____

_____

Drug/FoodAllergies:_____

_____

Medication Name OR Medical Procedure: _____ Diagnosis: _____

Starting Date: _____ Termination Date: _____

Physician's requirements of dosage or approved reasons for administration:

_____

_____

Time medication/medical procedure is to be provided daily: _____

Student is capable and recommended to possess and self-administer this medication/medical procedure:
No ____ Yes (unsupervised) ____

Precautions, possible side effects, interventions:_____

_____

Physician Name:_____

Physician's Address:_____

Telephone Number: _____

Physician's Signature: _____
Note: Physician's signature only required for prescription medications.

Parent(s)/guardian(s) by signature below acknowledge that the School is providing for the administration of medication/medical procedure as a courtesy to the parent(s)/guardian(s) and agrees to hold the School and School System harmless in its doing so.

Additionally, authorization is granted to obtain pertinent medical and/or copies of records pertaining to the student's medication and for this information to be shared with pertinent staff as needed. I understand that effective April 14, 2003, under the Health Insurance Portability and Accountability Act (HIPPA), disclosure of certain medical information is limited. However, I hereby authorize disclosure of pertinent medical information for the provision of services for my child while enrolled at Treasure Valley Classical Academy. This authorization expires as of the last day of this school year, including the summer/extended year session.

Parent/Guardian Signature: _____Date_____