



THE VAIL ACADEMY

Request for Medication Administration

(To be completed by parent or guardian)

Student's Name _____ Birthdate _____

Address _____ Phone _____

School _____ Grade _____

Parent's Name _____ Daytime phone _____

Emergency contact information _____

Medication to be administered _____

Dosage to be administered _____

Time or interval at which each dosage is to be administered _____

Name of physician authorizing administration _____

Address _____ Phone _____

Date to begin administration _____

Date to cease administration _____

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

Parent's Signature

Date