

**(To be completed by parent or guardian)**

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

Grade \_\_\_\_\_ Teacher's Name \_\_\_\_\_

Parent's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Medication to be administered \_\_\_\_\_ Dosage to be administered \_\_\_\_\_

Time or interval at which each dosage is to be administered \_\_\_\_\_

Date to begin administration \_\_\_\_\_ Date to cease administration \_\_\_\_\_

Name of physician authorizing administration \_\_\_\_\_

Address \_\_\_\_\_ Phone No. \_\_\_\_\_

**I request that Dominion Academy administer the above medication to my child in accordance with my request and the Physician's Statement of Need form. 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 the school in its 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 school year.**

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date