Venture Academy & Venture High School
Medical Authorization

☐ Request for School Personnel to Administer

☐ Kindergarten – 5th Grade Self-Administer Request w/ Approval from Doctor

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Name of Student:____

Grade: ______________ DOB:______________ Crew Teacher:________________

Address:________________________________ Home Phone:__________

Parent/Guardian:__________________________ Cell Phone:____________

Work Phone:__________

Emergency Contact:______________________ Phone:______________

Name of licensed health care provider completing form: (*Please Print*) ________________

Licensed Health Care Provider's Statement:

1. Name/type of medication:_____________________________________
2. Dosage/amount to be given:___________________________________
3. Frequency/times to be administered:____________________________
4. Duration (week, month, indefinite, etc.):_________________________
5. Self-Administer for students in grades Kindergarten – 5th requires Physician Approval

   (Please Initial best option)

   ____ No – School Personnel to administer

   ____ Yes - Self-administer (only required for grades Kinder – 5th)
6. Anticipated reactions to medication (symptoms, side effects for underdose/overdose, etc.)

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Signature of Licensed Health Care Provider ____________________Date__________

Parent/Guardian Request/Approval

I hereby request and give my permission for the above named student to receive and/or self-administer the specified medication as stated in the above instruction from the health care provider. I understand that the school administration will designate specific staff to administer medication, train staff, assure proper identification and safekeeping of medication, and maintain records of such administration of medication.

I further understand that school personnel who provide assistance (administration of specified medication so noted) or employer of such staff are not liable, civilly or criminally, for any adverse reaction suffered by my child as a result of taking the medication so indicated and discontinuing the administration of the medication in keeping with the procedure outlined above.

______________________________ ________________

Signature of Parent/Guardian Date