VICTORY CHRISTIAN ACADEMY

The Center for Lutheran Education

Physician's Recommendation for Medicine

Student's Name: _____ Date of Birth: _____

Home Phone: _____ Parent's Wk or Cell Phone: _____

This form must be completely filled out and signed annually by the student's parent/guardian and the student's authorized health care provider before the student can be assisted with the administration of medication by a staff/faculty member of Victory Christian. Academy.

To be Completed by Health Care Provider:

Name of Medication: _____ Dosage: _____

Method: _____ Schedule Given: _____

Purpose of Medication: _____ Duration: _____

Special Instructions: _____

Health Care Provider's Name (Print): _____

Health Care Provider's Signature: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Fax: _____ Date: _____

I agree that Victory Christian Academy, its officers, faculty and staff shall not be held liable for any loss, damage, injury or liability of any kind to any person caused or arising from acts, omissions or negligence of Lutheran High School, its officers, faculty and staff related to the administration of medication to my child.

I have read and understood this form and consent to the above provisions.

Parent/Guardian's Signature: _____ Date: _____

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