IDAHO NOVUS CLASSICAL ACADEMY
VIRTUS • SCIENTIA • FELICITAS

# Medical Administration Form 2026-2027

*Please complete a separate form for each type of medication or medical procedure to be administered.*

Student's Name: _____

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

Drug/Food Allergies: _____

Medication Name/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 Idaho Novus Classical Academy. This authorization expires as of the last day of this school year, including the summer/extended year session.*

Parent/Guardian Signature: _____

Date: _____