CORAM DEO
BIBLE CHURCH

MEDICATION ADMINISTRATION

Name of Student: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: ( ) _____-_____

Grade of Minor: _____ D.O.B. _____ / _____ / _____

Emergency Contact: _____ Phone: ( ) _____-_____

Doctor Name: _____ Phone: ( ) _____-_____

Name of Medication	**Dosage/Frequency**

I authorize Harvest Bible Chapel personnel to administer the above listed medications to my child.

Signature of Parent/Legal Guardian: _____

Print Name: _____ Date: _____