HARVEST BIBLE CHAPEL DAVENPORT

Harvest Students
Medication Administration Release Form

Name of Student: _____

Address: _____

City_____ State_____ Zip_____

Email: _____ Phone: ( ) _____-_____

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

Emergency Contact : _____ Phone: ( ) _____ - _____

Doctor's Name and Phone Number	Name of Medication	Dosage and Frequency

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

Signature of Parent/Legal Guardian: _____

Print Name: _____ Date: _____