Parent's Request to Administer Medication At School

Name of Student: _____D.O.B: _____/_____/_____

In order for my child to receive medication at Coeur Academy, I agree to the following:

- The prescription medication will be in a container labeled by the pharmacist or physician.
- All prescription medication and non-prescription medication is provided by the parents and will be in the original container with the label intact.
- Coeur Academy reserves the right to call the physician if a question arises about the child's medication.
- The first does of this medication has to be given to the child by parents without significant side effects or problems.

➢ Having read the above conditions, I request Coeur Academy personnel administer the medication as prescribed by the physician. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. It is my responsibility to provide updated medication information to staff.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Doctor's Name Phone Number

*If the student requires a medical plan, please sign below and attach the doctor approved medical plan to this form.

_____ _____

Signature of Parent/Guardian Date