# PARENT AGREEMENT
# for Medications and Self-Medicate Permission

I give permission for my daughter _____
to carry the doctor-prescribed medications and over the counter medications (advil, ibuprofen, benadryl, cold medication, etc.) listed below:

| Name of Medication | Dosage | Frequency |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

***If your daughter has an allergy or asthma diagnosis, an action plan must be submitted and signed by the prescribing physician.***

**I understand that my child is responsible for self-administering the medications and that Resurrection College Prep High School policy prohibits its employees from administering any medication to students in the normal discharge of their duties.**

**Parent Signature** _____ **Date** _____

**Student Signature** _____ **Date** _____

*FORMS ARE ONLY VALID FOR THE CURRENT SCHOOL YEAR AND MUST BE UPDATED YEARLY.*