



**PERMISSION FORM FOR ADMINISTRATION OF
 MEDICATION TO STUDENTS – 2017**

Name of Student:	
Class:	
Teachers Name:	
Name of Medication:	
Dosage:	
Times to be Administered:	
Method of Administration	
Duration of Medication	From: ____ / ____ / ____ Until: ____ / ____ / ____
Other Instructions:	

I hereby give permission for the College to administer the above medication according to the written instructions.

Name of Parent/Guardian _____

Signature of Parent / Guardian _____ Date: _____

**NOTE: UNLESS COMPLETED AND RETURNED TO THE CAMPUS NURSE,
 MEDICATION WILL NOT BE ADMINISTERED.**