OVERNEWTON
ANGLICAN COMMUNITY COLLEGE

PERMISSION FORM FOR ADMINISTRATION OF MEDICATION TO STUDENTS – 2018

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.

ADMINISTRATION OF MEDICINES TO STUDENTS

Date	Name of Student	Name of Medication	Dosage	Time	Signature