



## PERMISSION FORM FOR ADMINISTRATION OF MEDICATION TO STUDENTS – 2019

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.**

