# Administration of Medication to Students Register

**Staple Permission Note to This Sheet**

**Student Name:**

**Condition:**

**Doctor:**

**Phone:**

**Name of Medication:**

**Method of Administering the Medication:**

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**Principal's Signature:** .................................................................

Note the name of the Parent/Guardian who requested the medication administration.

**Name:** ................................................................. **Relationship:** .................................................................

**Contact Number:** .............................................. Unused medication returned to Parent **YES / NO**
PARENT / GUARDIAN’S AUTHORITY FORM FOR MEDICATION TO BE ADMINISTERED

Date: ________________

I hereby authorize medication to be administered to my child. Details are:

STUDENT'S NAME: ________________________ CLASS: ______

MEDICATION: ____________________________________________

TIME/S FOR ADMINISTRATION: _____________________________

DOCTOR WHO PRESCRIBED: ______________________________

PROBABLE PERIOD OF TREATMENT: _________________________

SIGNATURE OF PARENT / GUARDIAN

PHONE NUMBER