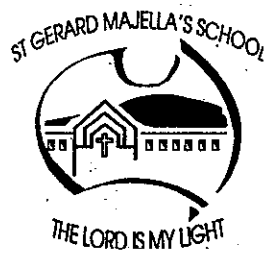

ADMINISTRATION OF MEDICATION TO STUDENTS REGISTER

STAPLE PERMISSION NOTE TO THIS SHEET

Student Name:
Condition:
Doctor:
Phone:
Name of Medication:
Method of Administering the Medication:

Dosage	Time	Date	Person who Administered	Dosage	Time	Date	Person who Administered
1				16			
2				17			
3				18			
4				19			
5				20			
6				21			
7				22			
8				23			
9				24			
10				25			
11				26			
12				27			
13				28			
14				29			
15				30			

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 PRESECRIBED: _____

PROBABLE PERIOD OF TREATMENT: _____

_____
SIGNATURE OF PARENT / GUARDIAN

_____
PHONE NUMBER