VILLANOVA COLLEGE

PERMISSION TO ADMINISTER STUDENT MEDICATION

To be completed by parent/guardian

Name of Student: _____ Year Level: _____

Name of Prescribing Doctor: _____

Reason for medication: _____

Medication Details

Condition	Medication name	Dosage	Time/s of administration	Special instructions	Self-administration (yes/no)

Signature of Parent/Guardian: _____ Date: _____