Medication Administration Consent Form

Student Information

Full Name

Date of Birth

Grade/Class

Parent/Guardian Information

Name

Contact Number

Medication Details

Medication Name

Dosage

Time(s) to be administered

Route

Duration (e.g., days, weeks)

Reason for Medication

Special Instructions

Instructions/Precautions

Consent

By signing below, I give permission for the above medication to be administered to my child as directed.

Parent/Guardian Signature

Date