

Permission to Administer Medications
Texas Tech Univeristy

*** Please fill out one form per medication

_____ has my permission to receive
(student's name)

_____ (drugs name) _____ (dose) _____ (time of day/Frequency)

Potential side effects (if any):

Prescribing physician (name, address and phone #):

Parent Name _____

Signature _____ Date _____