Health Services
Onondaga Community College

Medication Administration Authorization

Name of Child ____

Name of Medication ____
Dosage ____

Name of Physician ____

Signature of Physician _____________________________________

Prescription Number ____

Doses administered at Home __________________________________

Doses to be administered on Campus ___________________________

Number of days ____

Allergies, Additional Information ______________________________
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Signature of Parent _______________________________________

Date	Time	Medication/Dose	Nurse Initials

10/05