



Medication Permission Form

Student's Name: _____ Date: _____

I give permission to **The Southeast Youth Council, Inc., dba: Cornerstone Youth Center (CYC)** to administer medication to my above listed student. I will not hold CYC or its staff liable in the event of reactions, or complications arising from my student receiving this medication. I also understand that CYC staff will not give the first dose of this medication to my student, and that my student has taken this medication prior to it being given during CYC programs. I understand the Medication must be in original prescription container. The dosage and medication must match what is indicated on the container. Over the counter medication may be provided if new and in an unopened container. Legal guardian is contacted prior to administering any over the counter medication.

Legal Guardian: Print Full Name: _____

Legal Guardian Signature: _____ Date: _____

Directions to administer Medication:

1. Date to begin giving Medication:	2. Date to stop Medication:
3. Name of Medication:	4. Reason for Medication
5. Times Medication is to be given:	6. Dosage amount of Medication each time given:
7. Storage of Medication:	
8. Other Directions, if any:	
Signature of Legal Guardian:	Date:

Office Use: Completed by staff administering Medication:

Date	Time	Dose	Initials	Comments

