Canine College Student Medication/Supplement Form

Owners are required to complete this form whenever a dog enters our facility and owner requests we administer medications and/or supplements

Dogs Name: ___________________________________ **Date**: ________________________

Medical Condition Requiring Medication: ____

Name of Veterinarian who Prescribed Medication: ____

Name of Medication: ____

When: **AM** **NOON** **PM** **BED** **Other:** __________________________________

How Much Per Dose: _____________________ **How Med is Given**: ________________________________

I authorize Canine College to administer the above named medication/supplement to my dog as prescribed and authorized by me above.

Owner Signature (REQUIRED) ____

DO NOT WRITE BELOW THIS LINE. RESERVED FOR CANINE COLLEGE USE ONLY.

Weekday	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Date:							
AM							
Noon							
PM							

Weekday	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Date:							
AM							
Noon							
PM							

Weekday	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Date:							
AM							
Noon							
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