APPENDIX G (AP 3 32)

AUTHORIZATION OF PROVISION OF ORAL/TOPICAL Prescription MEDICATION

TO BE COMPLETED BY PARENT/GUARDIAN			
Name of Student			
Birthdate		**Grade**	
Address			
Postal Code		**Telephone**	
Parent's/Guardian's Name			
Business Address			
Postal Code		**Telephone**	

Condition of Patient for which Oral/Topical Prescription Medication is Necessary	
Name, Date and Amount of Prescription Medication to be provided by school staff	
Dosage/Amount to be Provided Each Time	·
Time(s) Dosage to be Provided for self-administration	·
Method of Administration by student (with Food?)	
Possible Side Effects	
Storage and Safekeeping Requirements for Prescription Medication	
Prescribing Physician's Name {Please Print}	
Physician Office Address and Telephone Number	

PARENT/GUARDIAN APPROVAL

I hereby request and give permission to {Name of School}______________________________________to provide Oral/topical prescription medication to my child according to School DSBN procedures and the instructions provided. I also affirm that the medication provided is the medication stated on the container provided to the school.

Signature of Parent/Guardian: ____ Date: ______________

Signature of Physician (**OPTIONAL**):____ Date: ______________