APPENDIX G

AUTHORIZATION OF PROVISION OF ORAL/TOPICAL 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**	

PARENT/GUARDIAN APPROVAL

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

Signature of Parent/Guardian: _____ Date: _____

TO BE COMPLETED BY PHYSICIAN

Condition of Patient for which Oral/Topical Medication is Necessary	
Name of Medication	
Dosage or Amount to be Given Each Time	As Indicated on Prescription Label
What Time(s) Dosage to be Given	As Indicated on Prescription Label
After Provision by the School, Who and How Will it be Administered (i.e., student, parent)	
Possible Side Effects	
Storage and Safekeeping Requirements for Medication	
Prescribing Physician's Name {Please Print}	
Office Address and Telephone Number	

Signature of Physician:_____ Date:_____