



AUTHORIZATION OF PROVISION OF ORAL/TOPICAL Prescription MEDICATION and Administration of RESCUE MEDICATION

| TO BE COMPLETED BY PARENT/GUARDIAN | | | |
|---|--|--|-----------|
| Name of Student | | | |
| Birthdate | | | Grade |
| Address | | | · |
| Postal Code | | | Telephone |
| Parent/Guardian 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 or staff administered rescue medication) | | | |
| 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: |