APPENDIX G (AP 3-32)

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: _____

Personal information and personal health information on this form is collected, used and disclosed in accordance with the Education Act, R.S.O. 1990, c.E.2, as amended, the Municipal Freedom of Information and Protection of Privacy Act. R.S.O 1990, c.M. 56, as amended and the Personal Health Information Protection Act, 2004, c.3 Sched. A., as amended and will be used for the purpose of providing student health information for the Plan of Care and any similar or related purpose(s). Questions about this collection, use and disclosure should be directed to the Freedom of Information Coordinator, District School Board of Niagara, 191 Carlton Street, St. Catharines, ON L2R 7P4 905-641-1550