APPENDIX G (AP 3-32)

# 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 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 |
| **Method of Administration (with Food?)** | |
| **Possible Side Effects** | |
| **Storage and Safekeeping Requirements for Medication** | |
| **Prescribing Physician's Name** {Please Print} | |
| **Office Address and Telephone Number** | |

Signature of Physician: _____ Date: _____