

AUTHORIZATION OF ADMINISTRATION 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			
<p>I hereby request and give permission to {Name of School} _____ to administer Oral/topical medication to my child according to School Board 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.</p>			
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: _____	