Appendix A

niagara children's centre school Weaving education and therapy together for student success.

AUTHORIZATION OF PROVISION OF ORAL/TOPICAL PRESCRIPTION MEDICATION		
TO BE COMPLETED BY PARENT/GUARDIAN		
STUDENT NAME		
BIRTHDATE		**GRADE**
ADDRESS		**PHONE NUMBER**
PARENT NAME		
HEALTH CARE PROVIDER INFORMATION		
Please review the NCCSA Plan of Care with your healthcare provider.		
Provider Name	Provider Address and Phone Number	☐ Physician ☐ Nurse Practitioner
Special Instructions from Health Care Provider		
Name of Medication		
DATE		
Date prescribed		
Dosage to be provided each time		
Times dosage to be provided		
Method of administration		
Possible side effects		
Storage and safekeeping s		
PARENT/GUARDIAN APPROVAL I hereby request and give permission to NCCSA to provide Oral/topical prescription medication to my child according to NCCSA 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 Health Care Provider **Optional** UNLESS medication is rescue medication.		
Signature of Parent/Guardian		DATE: