AUTHORIZATION OF PROVISION OF ORAL/TOPICAL PRESCRIPTION MEDICATION

TO BE COMPLETED BY PARENT/GUARDIAN

STUDENT NAME		
BIRTHDATE		**GRADE**
ADDRESS		**PHONE NUMBER**
PARENT NAME		
Condition of patient for which prescription medication is necessary		
Name of medication		
Date prescribed		
Dosage to be provided each time		
Times dosage to be provided		
Method of administration		
Possible side effects		
Storage and safekeeping requirements		
Prescribing Physician's Name (Print)		
Physician Office Address Phone Number		

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 Parent/Guardian	
DATE	
Signature of Physician NOTE **Optional** UNLESS medication is rescue medication.	
DATE	