Medical Provider Authorization Form

Student's Name: _____ Date of birth: _____

Student's Diagnosis: _____ School: _____

School District: _____is authorized to the give the following medication(s) to the above student.

Daily Medication

Medication/Dosage	Route	Frequency	Start Date	Stop Date	Considerations/Side Effects
1.					
2.					
3.					

As Needed or PRN Medication

Medication/Dosage	Route	Frequency	Start Date	Stop Date	Considerations/Side Effects
1.					
2.					
3.					

As a part of the Wisconsin Statute Chapter 118.29, school districts are required to have permission from a medical provider to administrator medications at school. As part of the authorization form, school district employees may contact the medical provider and parent with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above.

Print Medical Provider Name: _____

Medical Provider Signature: _____ Date: _____

Clinic _____ Phone Number: _____

Parent Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____