Medical Provider Authorization Form

Student's Name: ___________________________________ Date of birth: _________________________

Student's Diagnosis: ____

_______________________________is authorized to the give the following medication(s) to the above student.
(School Name)

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
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: _____________________________________ Date: ___________________

Medical Provider Signature: ____

Clinic: ____ Phone Number: ___________________