Parent/Guardian/Medical Provider Medication Authorization Form

Student's Name: ______________________________

Date of birth: ___________________

Address: ___________________________________ Grade: _____

As the parent and guardian of the above mentioned student, I give *St. Rose St. Mary's School* permission to administer the following medication(s) to my child for the following reason or diagnosis ____

Medication/Dosage	How to be given	How often	Start Date	Stop Date	Considerations/Side Effects
1.					
2.					
3.					

As the parent or guardian of the above mentioned student, I will keep *St. Rose St. Mary's School* aware of any changes in medication(s) profile or health concerns of my child.

As a part of the Wisconsin Statute Chapter 118.29, Administration of Drug to Pupils and Emergency Care, school districts are required to have permission from a medical provider and/or parent to administer medication at school. As part of this authorization form, *St. Rose St. Mary's School* employees may contact the medical provider with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above with parent permission.

Parent(s)/Guardian Signature: __________________________________ Date: ____________________

Print Medical Provider Name: ___________________________________ Date: ____________________

Medical Provider Signature: ____________________________________

Clinic: ______________________________________ Phone Number: ____________________________

Administered Medication Record

Student's Name: ________________________________ **Grade:** ______
Medication: _________________________ **When to be given:** ____________________________
Start Date: _________________________ **Stop Date:** _________________________
Special Instructions: ____

Date	Time	Initials	Date	Time	Initials	Date	Time	Initials