

## Medical Provider Authorization Form

Student's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Student's Diagnosis: \_\_\_\_\_

School District: \_\_\_\_\_ is authorized to 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
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 administer 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: \_\_\_\_\_