Parent(s)/Guardian Medication Authorization Form

Student's Name: _____ **Date of birth:** _____

Address: _____ **Grade:** _____

As the parent and guardian of the above mentioned student, I give the

St. Peter _____ **School District permission to administer the following medication(s)**

to my child for the following reason or diagnosis _____

_____.

Medication/Dosage (mg, cc, ml, etc)	**How it is 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 the school district aware of any changes in medication(s) profile or health concern 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 parent to administrator medications at school. As part of this authorization form, school district 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:** _____

Medical Provider Authorization Form

Student's Name: _____ **Date of birth:** _____

Student's Diagnosis: _____

School District: St. Peter Lutheran 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
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:** _____

Parent Signature _____ **Date** _____