Medication Authorization

This form must be completed if your child requires any medication at school.

STUDENT

Student Legal Name *(as it appears on birth record or other legal document)*				
Last Name	*First Name*	*Middle (full)*	*(Jr., II, III)*	*Nickname*
Gender	*Birth Date*	*Age*	*Grade*	

FOR COMPLETION BY PHYSICIAN

MEDICATION	**DOSE**	**TIME/FREQUENCY**
REASON FOR MEDICATION:		

PHYSICIAN SIGNATURE	DATE
_____	_____

Physician Name/Practice _____

Address _____

Phone _____ Fax _____

A physician signature for medication authorization is required by law and District policy.

Wisconsin Statute 118.291 and School District Policy require pupils to have written authorization by a physician and parent/guardian on file with the school administration for all medications including non-prescription medications. This includes pupils who carry and self-administer asthma inhalers. Additional authorization may be required for out of state / country or overnight field trips.

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FOR COMPLETION BY PARENT

As parent of the above named student I give permission for school staff to supervise the administration of the medication authorized by my physician. I agree to notify the school directly at the termination of this request, or when any changes in the above order are necessary. I authorize the school nurse to contact the physician directly for clarification of this medical order or to report any adverse reactions or side effects. I understand that it may be necessary to share the information on this form with other school staff to ensure proper administration of this medication. This information may also be shared with emergency medical staff in the event of a health or safety emergency necessitating transport to a medical facility.

PARENT SIGNATURE	DATE
_____	_____

Return via fax to your child's school: Cushing 262-646-6730 / Dousman 262-965-6559 / Magee 262-968-6471 / Wales 262-968-6405 / MS 262-965-6506 / HS 262-968-6217