Medical Provider Authorization Form for Prescription Medication

Student's Name	Date of birth
Reason for medication (diagnosis)	

Martin Luther School is authorized to the give the following medication(s) to the above student.

Daily Medication

Medication Strength & Dosage (mg, cc, ml, etc)	Route	Frequency	Start Date	Stop Date	Considerations/Side Effects
1.					
2.					
3.					

PRN Medication

Medication Strength & Dosage (mg, cc, ml, etc)	Route	Frequency	Start Date	Stop Date	Considerations
1.					
2.					
3.					

Print Medical Provider Name Date

Medical Provider Signature

Clinic Phone Number

- ALL tablets requiring splitting, must come pre-cut from home

As the parent or guardian of the child named above, I give Martin Luther School permission to administer the above listed medication(s) to my child for the above mentioned diagnosis. As the parent or guardian of the above mentioned child I agree to notify the school in writing of any changes in medication or health concern of my child. I agree to hold Martin Luther Church and School and its employees who are acting within the scope of their duties harmless from any and all claims arising from the administration of this medication.

As a part of Wisconsin Statute Chapter 118.29, Administration of Drug to Pupils and Emergency Care, schools are required to have permission from medical providers and parent to administer medications at school. As part of this authorization form, 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.

Print Parent/Guardian Name Date

Parent/Guardian Signature

Principal Signature