Authorization for Administration of Prescription Medication during School Hours

Student Name_____ Physician's Name_____

birth-date_____ Male____ Female ____ Physician's Address_____

School_____ _____

Parent (Guardian)_____ Physician's Phone_____

Home Phone_____ Work Phone_____ Physician's FAX_____

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To the Physician: According to the State of Wisconsin Medical Examining Board and St. Paul's Lutheran School's "School Medication Policy," it is required to fill out this form before the school personnel may dispense or administer medication.

Medication_____ Dose_____

Route: ___ Oral ___ Inhalation ___ Eye/ear/nose drops ___ Topical ___ Other
(if other, please specify_____)

Reason for this medication_____

Frequency_____

Time of Day_____ Length of time this medication is recommended_____

If medication is to be given "as needed," describe indications:_____

How soon can it be repeated?_____

Special Instructions_____

_____

Side Effects (expected or predictable)_____

Adverse Effects (which would require notification of parent and/or physician)_____

_____

Physician's Signature_____ Date_____

To the Parent/Guardian: By signing below, you request and authorize that your son/daughter be assisted in taking the medication described above at school by the designated school personnel.

Parent/Guardian Signature_____ Date_____