2019 - 2020

Medical Authorization Form

Student Name:_____ Date of Birth:_____

Student's Diagnosis:_____

School District: _____ is authorized to give the following medication(s) to the above student.

Daily Non – Prescription Medication or As Needed Medication

Medication/Dosage	Route	Frequency	Start Date	Stop Date	Considerations/Side Effects
1.					
2.					
3.					

Parent Signature: _____ Parent Phone Number:_____

Daily Prescription Medication or As Needed Prescription Medication

Medication/Dosage	Route	Frequency	Start Date	Stop Date	Considerations/Side Effects
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: _____

Parent Signature: _____ Parent Phone Number:_____