Our Savior Lutheran School
Medical Provider Authorization Form
For Prescription Medication

Student's Name: ______________________ **D.O.B:** ____________ **Grade:** ______

Diagnosis: ____

Our Savior Lutheran School is authorized to 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/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 prescription medications at school. As part of the authorization form, school 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: ________________

Our Savior Lutheran School
Asthma Inhaler Administration Authorization Form

Student's Name: ______________________________ **D.O.B:** ______________ **Grade:** ______

Diagnosis: ____

In order for the student to receive the asthma relieving medication for asthma:

- Asthma inhaler administration authorization form will be completed and signed by parent and medical provider. Form will be given to school principal or school office.
- Asthma inhaler medication will have student's name, name of medication, directions for use and date.
- Authorization of asthma relieving medication will be updated annually.

The student has the skill, knowledge and my authorization to use an asthma relieving medication in the following manner:

_____ Self-administer asthma relieving medication. Student will seek the care of the school personnel if medication is unsuccessfully controlling his/her asthma.
_____ Self-administer asthma relieving medication with access to another inhaler in the health office as needed. Parents will supply health office secondary inhaler.
_____ Student needs assistance with administration of their asthma relieving medication with the medication available as needed in the health office.

Drug name:	Dosage:	Route:	Frequency:	Start date:	Stop date:	Side Effects:

School personnel may contact the medical provider of the medication for clarification regarding indication for use, medication, dosage, side effects, successful and treatment failures.

Physician's Name:	Clinic/Phone:
Physician's signature:	Date:
Parent/Guardian signature:	Date:

School Administrator Authorization: ________________________________ Date: ______________

Our Savior Lutheran School
Parent/Guardian Authorization for Medication

Student's Name: ______________________ **D.O.B:** ____________ **Grade:** ______

Address: ____

As the parent of the above mentioned student, I give Our Savior Lutheran School permission to administer the following medication(s) to my child for the following reason or diagnosis:

____

____

Further, I understand it is my responsibility to furnish the medication for each student in original packaging to the office.

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 Our Savior Lutheran School 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, schools are required to have permission from a medical provider and parent to administrate prescription 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.

Parent(s)/Guardian Signature: ________________________________ Date: ______________