

Medical Provider Authorization Form for Prescription Medication

Our Savior Lutheran School

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Our Savior
LUTHERAN CHURCH & SCHOOL

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: _____