Medication Authorization Form

Student's Name: _____ Date of birth: _____

Student's Diagnosis: _____

As a part of the Wisconsin Statute Chapter 118.29, school districts are required to have permission from a medical provider to administrator prescription 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.

Practitioner/Medical provider signature is ONLY required for prescription medication.

Prescription Medication

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

SELF-CARRY MEDICATION SECTION (Epi Auto-injectors, Insulin and Inhalers Only)
Student is properly instructed on how to self-administer? YES/NO
Student can demonstrate proper technique? YES/NO
Student can verbalize when to self-administer? YES/NO

Print Medical Provider Name: _____ Date: _____

Medical Provider Signature: _____

Clinic _____ Phone Number: _____

Parent/Guardian Signature:_____ Date:_____

Non-Prescription Medication

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

Parent/Guardian Signature:_____ Date:_____

Please ask the pharmacist for a separate medicine bottle to keep at school. Provide extra label for inhaler, Epi Pens, insulin, emergency seizure medications, etc. Thank you!

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