Medical Provider Administration of Consent

Student's Name: _____ Date of birth: ____ / ____ / _____

Student's Diagnosis:_____

Mount Olive Lutheran School is authorized to administer the following medications to the student listed above.

DAILY MEDICATIONS:

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

AS NEEDED or PRN MEDICATIONS:

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

As a part of the Wisconsin Statute Chapter 118.29, Administration of Drug to Pupils and Emergency Care, schools are required to have written permission from a medical provider to administer prescription medications at school. As part of this authorization form, school district 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.

Print Medical Provider Name: _____ Clinic: _____

Medical Provider's Signature: _____ Date: ____ / ____ / _____

Medical Provider's Phone Number (_____) _____ - _____