Parent/Guardian Administration of Consent

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

As the parent / guardian of the above mentioned student, I give Mount Olive Lutheran School permission to administer the medication(s) listed below to my child for the following reason or diagnosis _____

_____

Medication/Dosage (mg, cc, ml, etc)	How it is to be given	Time(s) it is to be given	Start Date	Stop Date	Considerations/Side Effects
1.			/ /	/ /	
2.			/ /	/ /	
3.			/ /	/ /	

As the parent or guardian of the above mentioned student, I will keep the school aware of any changes in medication(s) profile or health concerns 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 written permission from a parent / guardian to administer 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.

Parent / Guardian Signature: _____ Date: ____ / ____ / _____

Physician's Name: _____ Physician's Phone Number (_____) _____ - _____