Faith Lutheran School
Fond du Lac, Wisconsin

Medical Provider Authorization Form

Student's Name: ______________________________ Date of birth: ________________________

Student's Diagnosis: ____

Faith Lutheran School is authorized to the 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
1.					
2.					
3.					

As a part of the Wisconsin Statute Chapter 118.29, schools are required to have permission from a medical provider to administrator medications at school. As part of the authorization form, school staff members 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: _________________