Parent's Medical Authorization Form

(use for NON-PRESCRIPTION medication at school)

Student Name_____Date of Birth_____

Parent Name _____Parent Phone # _____

Diagnosis: _____

As the parent/guardian of the above mentioned student, I give St. Paul Ev. Lutheran School permission to administer medication(s) to my child under circumstances described below…

Medication/Dosage (mg, cc, ml, tablet, etc)	Route of entry	Frequency	Start Date	Stop Date	Considerations/ Side Effects

As the parent/guardian of the above mentioned, I will keep St. Paul's School informed of any needed changes in medication(s) to modify my child's health program by submitting a new authorization form.

Parent(s) Guardian Signature: _____ Date: _____

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Student Self-Administered Medication Form

(parent permission for SELF-ADMINISTERED non-prescription medication)

Student Name_____Date of Birth_____

Parent Name _____Parent Phone # _____

Diagnosis: _____

As parent/guardian, I give my child (named above) permission to self-medicate one dose of a non-prescription medication at school under circumstances described below…

Medication/Dosage (mg, cc, ml, tablet, etc)	Route of entry	Frequency	Start Date	Stop Date	Considerations/ Side Effects

While granting my child permission to self-medicate one dose of a non-prescription drug, I am assuring the school that there is a need, that child will keep the medication secure in his/her personal possession & that he/she will accompany the medication with this signed form while at school.

Parent's signature_____Date_____

(*Parents,* please bring this form to school office with medication in original prescription bottle properly labeled.
***Office staff,* copy this form placing original in the student health file, giving duplicate/log & medication to teacher.**
***Teacher,* place meds in secure location, duplicate/log form in class notebook, administer/record as instructed.**
***Students,* if self-administering one dose of non-prescription medication, keep this note secure with medication.)**

Asthma Inhaler Administration Authorization Form

Student Name_____Date of Birth_____

Parent Signature _____Parent Phone # _____

Diagnosis: _____

In order for the student to receive the asthma relieving medication for asthma:

- Asthma inhaler administration authorization form must be completed & signed by parent and medical provider. Form will be returned to the school office.
- Asthma inhaler medication must be properly labeled (medication/student names and directions for use.)
- The authorization of asthma relieving medication must be updated annually for use at school.

Students need skill, knowledge & authorization to use asthma relieving medication. Below are varied levels of administration. **Please check** all levels that you desire based on this child's skill and knowledge.

____ Student can self-administer asthma relieving medication. Student will seek the care of the school personnel if medication is unsuccessfully controlling his/her asthma.

____ Student can self-administer asthma relieving medication with access to another inhaler in the school if needed. (Parents will supply school with a secondary inhaler.)

____ Teacher needs to assist student in administrating the asthma relieving medication with the medication available as needed in the school.

Drug name:	Dosage:	Route:	Frequency:	Start date:	Stop date:	Side Effects:
1.						
2.						

School personnel may contact the medical provider of the medication for clarification regarding indication for use, medication, dosage, side effects, successful and treatment failures.

Medical Provider Signature:_____ Date:_____

Medical Provider Name: _____Phone #_____
(please print)

Clinic Offices: _____ Phone #_____
(please print)

(*Parents*, please bring this form to school office with medication in original prescription bottle properly labeled. *Office staff*, copy this form placing original in the student health file, giving duplicate/log & medication to teacher. *Teacher*, place meds in secure location, duplicate/log form in class notebook, administer/record as instructed.)

Medical Provider's School Authorization Form
(for prescription medication)

Student Name _____ Date of birth: _____

Parent Signature_____ Parent Phone #_____

Student Diagnosis: _____

St. Paul Ev. Lutheran School is authorized to give the following medication(s) to above named student…

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

Medicine as needed (PRN) … Dosage	Route	Frequency	Start Date	Stop Date	Considerations/Side Effects

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 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.

Medical Provider Signature:_____ Date:_____

Medical Provider Name: _____Phone #_____
(please print)

Clinic Offices: _____ Phone #_____
(please print)

(*Parents*, please bring this form to school office with medication in original prescription bottle properly labeled. *Office staff*, copy this form placing original in the student health file, giving duplicate/log & medication to teacher. *Teacher*, place meds in secure location, duplicate/log form in class notebook, administer/record as instructed.)