

Medication Authorization Form

Medical Provider (prescription meds)

Student's Name: _____ Date of birth: _____

Student's Diagnosis: _____

Trinity Lutheran School is authorized to give the following medication(s) to the above student.

Daily Medication

Medication Name and Dosage	Route	Frequency	Start Date	Stop Date	Considerations/ Side Effects

As Needed or PRN Medication

Medication Name and Dosage	Route	Frequency	Start Date	Stop Date	Considerations/ Side Effects

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

Print Medical Provider Name: _____ Date: _____

Medical Provider Signature: _____

Clinic _____ Phone Number: _____