

Medication Authorization Form

Parent/Guardian (non-prescription meds)

Student's Name: _____ Date of birth: _____

Address: _____ Grade: _____

As the parent and guardian of the above-mentioned student, I give St. Matthew's Lutheran School permission to administer the following medication (below in chart) to my child for the following reason or diagnosis: _____
 _____.

Medication/Dosage (mg, cc, ml, etc)	How it is to be given	How often	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 or health concern of my child.

As a part of the Wisconsin Statute Chapter 118.29, Administration of Drug to Pupils and Emergency Care, school districts are required to have permission from a medical provider and parent 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(s) Guardian Signature: _____ Date: _____