IOWA-GRANT ELEM/MIDDLE SCHOOL MEDICAL PROVIDER AUTHORIZATION FORM
2017-2018 SCHOOL YEAR

(This form only needs to be filled out if the school is administering prescription medication to a student during school hours.)

Prescription Medications

Student's Name: ______________________________ Date of Birth: _______________________

Student's Diagnosis: ____

Iowa-Grant Elem/Middle School is authorized to the give the following medication(s) to the above student. All medications must be furnished by the parent and are to be in the original prescription bottle labeled with the name of the medication, the amount and directions. Do not send medication in baggies or envelopes as they will not be accepted by office staff.

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, school districts are required to have permission from a medical provider to administrator 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: ____

Parent Signature____Phone #:_____________