

Medication Authorization Form



Student Information (Complete an Application for Each Child)

Child's Name (Last, First, Middle)	Date of Birth	Age	Grade
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As the parent and guardian of the above-mentioned student, I give Saint Lucas Lutheran School permission to administer the following medication(s) 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	End Date	Considerations/Side Effects
1.					
2.					
3.					
4.					

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.

As the parent or guardian of the above mentioned student, I will keep Saint Lucas Lutheran School aware of any changes in medication(s) profile or health concern of my child.

Parent's/Guardian's Signature: _____ Date _____

_____ Date _____