# Medical Provider Authorization Form

Saint Lucas LUTHERAN SCHOOL

## Student Information (Complete an Application for Each Child)

| Child's Name (Last, First, Middle) | Date of Birth | Age | Grade |
|---|---|---|---|
| | | | |

Diagnosis

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

**Daily Medication**

| Medication/Dosage (mg, cc, ml, etc) | Route | Frequency | Start Date | End Date | Considerations/ Side Effects |
|---|---|---|---|---|---|
| **1.** | | | | | |
| **2.** | | | | | |

**As Needed or PRN Medication**

| Medication/Dosage (mg, cc, ml, etc) | Route | Frequency | Start Date | End Date | Considerations |
|---|---|---|---|---|---|
| **1.** | | | | | |
| **2.** | | | | | |

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.

Name of Child's Physician

| Name of Physician's Medical Center/Clinic | Medical Center/Clinic Phone Number |
|---|---|
| Physician's Signature | Date |

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

_____ Date _____