ST. PAUL'S EV LUTHERAN SCHOOL
PERMISSION TO ADMINISTER MEDICATION FORM

Please fill out form for **EACH MEDICATION** and bring to school office. Medicines will be kept in office. Medicines must be in their original container.

Student's Name: _____Grade/Classroom: _____

Name of Medical Provider: _____ Phone Number: _____

Medication: _____ Prescription _____OTC_____

When to be given: _____ How to be given: _____

Dosage (mg. cc.ml. tsp. etc.): _____ Purpose_____

Start date: _____ Stop date: _____

Special considerations/Side Effects: _____

_____

Enter time medication given/Initials

Date	Time	Initials	Date	Time	Initials	Date	Time	Initials

School personnel authorized to administer the medication:

1. **_____ Initials: _____ Date: _____**
2. **_____ Initials: _____ Date: _____**
3. **_____ Initials: _____ Date: _____**

As the parent or guardian of the above-mentioned student, I will keep St. Paul's Ev. Lutheran School aware of any changes in medication(s) profile 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 administrator medications at school. As part of this authorization form, school district employees may contact the medical provider regarding questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above with parent permission.

Parent/Guardian Signature: _____ Date: _____

Physician Signature: _____ Date: _____