Medical Provider Authorization Form

Student's Name: ______________________________ Date of birth: ________________________

Rib Lake School District is authorized to give the following medication(s) to the above student.

Daily Medication

Medication Name and Strength:____

Dose:____

Route:____

Time to be administered at school:____

Date order effective from:_____________________ To:_____________________________

Diagnosis/Reason for Medication:____

Medication Name and Strength:____

Dose:____

Route:____

Time to be administered at school:____

Date order effective from:_____________________ To:_____________________________

Diagnosis/Reason for Medication:____

As Needed or PRN Medication

Medication Name and Strength:____

Dose:____

Route:____

Time to be administered at school:____

Date order effective from:_____________________ To:_____________________________

Diagnosis/Reason for Medication:____

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.

Print Medical Provider Name: _________________________________ Date: __________________

Medical Provider Signature: ____

Clinic ____ Phone Number: _________________