PRESCRIPTION MEDICATION PERMISSION FORM

PHYSICIAN AND PARENT REQUEST FOR SCHOOL ADMINISTRATION OF MEDICATION (Wisconsin Statute 118.29, 118.291 and 118.292)

Date Form Received by	the School:		
Name:			Date of Birth or Age:
Grade:	Teacher/Classroom:		
TO BE COMPLETED	BY AUTHORIZED I	HEALTH CARE PE	ROVIDER
Form of Medication/	,		
□ Tablet/capsule □ !	Liquid □ Inhaler □	□ Injection □ Neb	ulizer Other:
·	•	•	
man donono (CoCa.	ile and dood to be g	/611 at 3011001 ₇	
Restrictions and/or I	-	•	pated
Special Storage Req	juirements: □ None	□ Refrigerate □	□ Locked □ Other:
Duration:			
Start: date form rece			Other date:
Stop: □ end of school	year (may include su	ımmer school) 🛛	Other date:
For Inhaled Medicati This student is capabl □ No □ Yes-Su		r carrying and self-	
For Other Non-Control This student is capable One No Yes		_	administering:
The health care provider whos also agrees to accept communication the medication of the accept communication of the medication of the accept communication of the accept c	nication regarding the admini	authorizes school personnistration procedures. It is	nel to administer medication/treatment as prescribed and understood that non-licensed, trained personnel may
Provider Signature/Title	Print (Ordering Provider Nam	Date
Address			Phone Number
	THE COURSE AND CO		
TO BE COMPLETED If provider checked yes			tudent capable and responsible to do so:
□ No □ Yes			
	Signature		Date
	ave my permission to a cy. Per WI N6.03 Nurs	dminister this medica se Practice Standards	TIVE ation/treatment as indicated above and s, the nurse may consult with the provider if
Parent/Legal Representativ	ve Signature	Relationship	Date