Medication Authorization Form

St. Bernard Catholic School
2018-2019

Student Name ____Grade ______

Student Address ____

Phone ______________________________ Birthdate _____________________

Physician's Name ______________________________ Phone _______________

Name of Medication ____

Check one: _______ non-prescription _______ prescription

Reason Medication is to be given _______________________________________

Amount to be given ____

Route to be given _____________How often to given ______________________

Date/s to be given ____

Time of day to be given ____

Possible side effects ____

As the parent/guardian, of the above mentioned student, I give St. Bernard School permission to administer the medication indicated above. I will keep the school aware of any changes in medication(s) profile or health concerns of my child. **We do not administer any medication that does not have the prescription label or over the counter label on the container.**

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/or parent to administer medication at school. As part of this authorization form, school 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.

Parent/Guardian Signature ____________________________________ Date _____________________________