Mount Calvary Lutheran School

Waukesha, Wisconsin

Prescription / Medication Authorization – Parent/Guardian Form

Use one form per medication.

Student Name: _____ Date of Birth: _____ Grade: _____

Medication Name: _____

Dosage: _____ Method of Administration: _____ Frequency: _____

Starting Date: _____ Ending Date: _____

Reason for Medication: _____

If “as needed,” conditions under which medication should be given: _____

_____

Precautions, possible undesirable reactions, and/or interventions: _____

_____

Did a physician prescribe the medication? Yes** _____ No _____

Physician’s Name: _____ Phone: _____

Address: _____

**Submit “Medication Authorization-Physician Form” or Physician’s signed statement.

• I give my permission to school personnel to give this medication to my child according to the directions stated above and to contact my child’s physician if necessary.

• I agree to hold the school and personnel harmless in any claims arising from the administration of this medication at school.

• I agree to notify the school in writing when any change in the above orders is necessary.

_____ _____

Signature of Parent/Guardian Date

Mount Calvary Lutheran School

Waukesha, Wisconsin

Prescription Medication Authorization – Physician Form

Permission is granted for non medical school personnel to administer medication as follows:

Student: _____ Date of birth: _____

Medication name: _____

Dosage: _____ Method of administration: _____

Time/Frequency: _____ Duration: _____

Diagnosis: _____

Precautions, interventions, comments: _____

_____

_____

_____

I am willing to be contacted by school personnel with concerns or questions regarding the above medication administration.

PLEASE PRINT:

_____

Physician Name

_____

Address

_____

Physician Telephone Number

_____ _____

Physician's Signature Date