St. John Nepomucene School

328 S. Grand Avenue

Little Chute, WI 54140

PARENT REQUEST and AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION

Student's Name: _____

Birthdate: _____ Grade: _____

Reason for Medication: _____

Dosage of Medication (not to exceed written label directions without a physician's orders):

When It Should Be Given: _____

Start Date:_____ Stop Date: _____

Is this a scheduled medication or an as needed medication? _____

Considerations/Side Effects: _____

Guidelines

1. I will notify St. John School immediately if there is a change in the use of the above prescription.
2. I release and agree to hold harmless St. John School, its employees, officers, and staff from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Name Printed: _____

Parent/Guardian Signature: _____

Phone Number: _____

Date: _____

St. John Nepomucene School

DOCTOR REQUEST and AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION

Student's Name: _____

Birthdate: _____ Grade: _____

I am a licensed healthcare professional authorized to prescribe drugs, and I have prescribed the following medication to the above named student.

Name of Medication: _____

Reason for Medication: _____

Dosage of Medication (not to exceed written label directions without a physician's orders):

_____

When It Should Be Given: _____

Start Date: _____ Stop Date: _____

Specific medication side effects under which contact should be made with you: _____

_____

Is this a daily medication or an as needed medication? _____

As a part of the Wisconsin Statute Chapter 118.29, school districts are required to have permission from a medical provider to administer prescription 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 below. We urge that all instructions be stated in language of the lay person.

Prescriber's Name Printed: _____

Prescriber's Signature: _____

Date: _____ Phone: _____