We exist to exalt the Lord, educate his children, and evangelize the world

Bethlehem Lutheran School
Medical Provider Authorization Form
For Prescription Medication

Student's Name: _____ Date of birth: _____

Student's Diagnosis: _____

Bethlehem Lutheran School is authorized to give the following medication(s) to the above student.

Daily Medication

Medication/Dosage	Route	Frequency	Start Date	Stop Date	Considerations/Side Effects
1.					
2.					
3.					

As Needed or PRN Medication

Medication/Dosage	Route	Frequency	Start Date	Stop Date	Considerations
1.					
2.					
3.					

As a part of the Wisconsin Statute Chapter 118.29, school districts are required to have permission from a medical provider to administrator 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 above.

Print Medical Provider Name: _____ Date: _____

Medical Provider Signature: _____

Clinic _____ Phone Number: _____