ARCHDIOCESE OF MILWAUKEE

Form 5140.2(b)

Medical Provider Authorization Form
Prescription Medication

Student's Name: ______________________________ **Date of birth:** ______________

School: ____ **Grade:** __________

Diagnosis: ____

Daily Medication

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

As Needed or PRN Medication

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

Medical Provider Consent

I authorize the school to the give the above medication(s) to this student.

Asthma Inhalers and Epi-Pens Only: This student and his/her parents have been instructed in self-administration and the student may carry an inhaler or Epi-Pen and self administer at school. Yes_______ No_______

Print Medical Provider Name: ______________________________ **Phone** ______________

Medical Provider Signature: ______________________________ **Date:** ______________

Parent Consent

I give the school permission to administer the above medications as directed by the medical provider.
Inhaler/Epi-Pen Only: My child may _______ or may not _______ carry and self administer.

Parent/Guardian Signature: ______________________________ **Date:** ______________

As part of the authorization form, school personnel 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.