MILWAUKEE
PUBLIC SCHOOLS

Department of Specialized Services
Nursing
6620 W. Capitol Dr.
Milwaukee, WI 53216
(414) 438-3648 • mps.milwaukee.k12.wi.us

# AUTHORIZATION TO DISCONTINUE MEDICATION

Health Care Provider: The medication for the student below has changed. Please note the listed change and sign and fax the discontinue order back to school. Thank you.

Name of Student: Date of Birth: _____

School:

Fax number:

School Nurse:

Name of Parent(s)/Guardian:

Phone: (Home) (Work) (Cell)

Name of Medication:

Dosage:

Date to Stop:

☐ Parent reports change of medication, new order form attached.

☐ Parent has failed to provide medication since: _____

☐ Student is no longer attending Milwaukee Public Schools.

Name of Prescribing Medical Provider: _____

Signature of Prescribing Medical Provider: _____ Date: _____

Health Care Provider Address: _____

Health Care Provider's Phone Number: _____

Health Care Provider's Fax Number: _____

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Parent/Guardian Signature:

_____ Date: _____