MILWAUKEE PUBLIC SCHOOLS

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

MEDICATION/PROCEDURE AUTHORIZATION

Student's Name: _____ Student ID #:_____

School: _____ Grade: _____ Date of Birth: _____

Diagnosis: 1._____ 2. _____

Parent Permission

I am requesting that my child, _____, receive prescription drugs or procedures at the time indicated and as designated by his/her medical provider.

I will be responsible for bringing the prescription drugs to school in a labeled container from the pharmacist. I also understand that I am responsible for maintaining a sufficient quantity of the medication or supplies at the school. Failure to do this will result in an interruption of the physician's order or discontinuation of the school's administration of the medication/procedure for my child. I understand that, if my child refuses to take the prescribed medication(s) or allow the procedure(s), force will not be used by school personnel to make my child comply.

School personnel have permission to communicate with the prescribing medical provider regarding use, side effects, response, and contraindications of the medication(s) or the procedure results or frequency. I can rescind my permission at any time.

_____ _____ _____

Signature of Parent/Legal Guardian | Relationship | Date: (Mo./Day/Yr.)

Health Care Provider Authorization:

I am prescribing the following medication and procedures for the above student to be administered or performed at school.

DAILY

Name of Daily Medication (Generic and Trade Name)	Dosage/ Frequency	Time(s) (AM/PM):	Start date	Stop date	Possible Adverse Side Effect or Contraindications:

PRN

Name of PRN Medication (Generic and Trade Name)	Dosage/ Frequency	Time(s) (AM/PM):	Start date	Stop date	Possible Adverse Side Effect or Contraindications:

Name of Procedure (CIC, glucose checks, suctioning, etc.):	Dosage/ Frequency	Time(s) (AM/PM):	Start date	Stop date	Monitoring Parameters

PROCEDURES

The above orders shall be effective throughout the current school year, summer school and through September 30th of the following school year, unless the orders are discontinued, changed or withdrawn in writing by the parent/guardian before that time elapses.

Medical Provider's Signature

Date (Mo./Day/Yr.)

Telephone/Fax Number

Printed Medical Provider's Name

Address

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