

**Randolph Christian School  
Medical Provider Authorization Form**

Student's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Student's Diagnosis: \_\_\_\_\_

Randolph Christian School is authorized to the 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 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: \_\_\_\_\_

**Randolph Christian School  
Parent Medication Authorization Form**

Student's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_ Grade: \_\_\_\_\_

As the parent and guardian of the above mentioned student, I give Randolph Christian School permission to administer the following medication(s)

to my child for the following reason or diagnosis \_\_\_\_\_

Medication/Dosage (mg, cc, ml, etc)	How it is to be given	How often	Start Date	Stop Date	Considerations/ Side Effects
1.					
2.					
3.					

As the parent or guardian of the above mentioned student, I will keep the school aware of any changes in medication(s) profile or health concern of my child.

As a part of the Wisconsin Statute Chapter 118.29, Administration of Drug to Pupils and Emergency Care, schools are required to have permission from a medical provider and parent to administer medications at school. As part of this authorization form, school employees may contact the medical provider with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above with parent permission.

Parent(s) Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Randolph Christian School  
Asthma Inhaler Administration Authorization Form**

**Student's Name:** \_\_\_\_\_ **D.O.B:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

In order for the student to receive the asthma relieving medication for asthma:

- Asthma inhaler administration authorization form will be completed and signed by parent and medical provider. Form will be given to the office.
- Asthma inhaler medication will have student's name, name of medication, directions for use and date.
- Authorization of asthma relieving medication will be updated annually.

The student has the skill, knowledge and my authorization to use an asthma relieving medication in the following manner:

- \_\_\_\_\_ Self-administer asthma relieving medication. Student will seek the care of the school personnel if medication is unsuccessfully controlling his/her asthma.
- \_\_\_\_\_ Self-administer asthma relieving medication with access to another inhaler in the health office as needed. Parents will supply office with inhaler.
- \_\_\_\_\_ Student needs assistance with administration of their asthma relieving medication with the medication available as needed in the office.

Drug name:	Dosage:	Route:	Frequency:	Start date:	Stop date:	Side Effects:
1.						
2.						

School personnel may contact the medical provider of the medication for clarification regarding indication for use, medication, dosage, side effects, successful and treatment failures.

Physician's name:	Clinic/Phone:
Physician's signature:	Date:
Parent/Guardian signature	Date:

School Administrator Authorization: \_\_\_\_\_ Date: \_\_\_\_\_