Milwaukee Seventh-day Adventist School
(updated 7-1-19)

Medical Provider's Order for Administration of Prescription Medication
Parent/Guardian Consent Form for Prescription Medication

Please Print

This order and consent for medication is required to be completed and presented to the child's school before any medication may be administered to a child during the school day.

Name of Student: _____
Date of Birth: _____ Grade: _____
Address: _____
Home Phone: _____Mother's Cell: _____ Father's Cell: _____

- I grant permission to the persons designated by the principal to give medication(s) to my child according to the directions.
- As a Parent or guardian I understand that I must provide all medications to the school.
- All medications must be in their original containers.
- I authorize school personnel to exchange information with my child's medical provider regarding this medication or the condition for which it is prescribed.
- I release the school from any liability claims of the administration of this medication as directed.
- I will notify the school in writing of any changes. Prescription medication changes require a new medical provider's order.
- I understand that as the parent or guardian, I will be responsible to transport the medication to and from the school to the authorized personnel designated to give medications.
- I understand all medication must be picked up by the parent or guardian at the end of the school year or it will be destroyed.

MUST BE SIGNED IF MEDICATION IS TO BE ADMINISTERED BY THE SCHOOL:
Authorized school personnel may give my child medication as listed by parent, guardian or medical provider.
Signature of Parent or Guardian: _____
Date: _____

Medical Provider's Order for Each Prescription Medication

Medication Name: _____
Diagnosis: _____
Medication side effects: _____
Dose: _____ _____Frequency: _____
How to be administered: Orally _____ Other _____ (If other, please list how) _____
Duration: Entire School Year ____ or Number of days _____ Starting date: _____
Special Instructions: _____
Medications used on an as needed basis, should be given during what conditions: _____
The student may take the above listed medication at school without authorized school personnel dispensing the medication. (Example: Asthma Inhalers) Yes: _____ No: _____

Print Medical Provider's Name : _____ Date: _____
Medical Provider's Signature: _____
Medical Provider's signature required for all prescription medications
Clinic: _____ Phone Number: _____

Wisconsin Statute 118.29, 118.291