MILWAUKEE
PUBLIC SCHOOLS

Name:_____ Student ID #:_____

School:_____ Grade:_____ Date of Birth:_____

MEDICATION and PROCEDURE PERMISSION AND INSTRUCTION FORM

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 or druggist. I also understand that I am responsible for maintaining a sufficient quantity of the medication or supplies for procedure at the school to avoid any interruptions in the physician's orders. Failure to do this will result in termination of the school's administration of the medication and/or procedure for my child. I understand that, if my child refuses to take the prescribed drug(s) or allow the procedures, force will not be used by school personnel to make my child comply.

School personnel have permission to communicate with the medical provider prescribing the medication 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.)

(OVER)

Medical Provider Permission:

Name:_____Student ID #:_____

School:_____Grade:_____Date of Birth:_____

Diagnosis: 1._____ 2. _____

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 and 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 and Frequency	Time(s) (AM/PM):	Start date	Stop date	Possible Adverse Side Effect or Contraindications:

Procedures

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

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school and through September 30th of the following next school year, unless the orders are discontinued, changed or withdrawn in writing by the parent/guardian before that time elapses.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