CHESTERTON ACADEMY OF MILWAUKEE

MEDICAL PROVIDER AUTHORIZATION FORM/PRESCRIPTION MEDICATION

Student's Name:	DOB:
Grade:	Diagnosis:

Medical Information

Allergies:
Other Medical Conditions:

DAILY MEDICATION

Medication: 1.	Dosage:	Route:	Frequency:	Start Date:	Stop Date:	Side Effects:
2.						

AS NEEDED OR PRN MEDICATION

Medication: 1.	Dosage:	Route:	Frequency:	Start Date:	Stop Date:	Side Effects:
2.						

MEDICAL PROVIDER CONSENT

I authorize the school to the give the above medication(s) to this student. Asthma Inhalers and Epi-Pens Only: This student and his/her parents have been instructed in self-administration and the student may carry an inhaler or Epi-Pen and self-administer at school. Yes ☐ No ☐	
Print Medical Provider Name:	Date:
Medical Provider Signature:	

PARENT CONSENT

I give the school permission to administer the above medications as directed by the medical provider. Inhaler/Epi-Pen Only: My child ☐ may or ☐ may not carry and self-administer.	
Parent/Guardian Signature:	Date:

By entering my full name, I attest that this constitutes my legal electronic signature on this form.

As part of the authorization form, school personnel 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.