Emergency/Self-Administered Medication Authorization Form

Student's Name:_____ Date of Birth: _____

In order for the student to receive emergency medication for potential health conditions such as allergic reaction or hypoglycemia; or to carry self administering medication such as an insulin pump the following conditions need to be met:

- Emergency/Self-Administered Medication administration authorization form will be completed and signed by parent and medical provider. Form will be given to the main office for administrator approval.
- Emergency/Self-Administered Medication container will have affixed a label reciting the student's name, name of medication, directions for use and date, name of prescribing physician, and physician's phone number.
- Authorization of emergency medicine or other approved self administered medication will be updated annually or whenever changes are made to dosing, frequency, or other changes to its administration.

The student has permission to carry the following emergency medication(s) for the following reasons:

Medication: _____ Reason: _____

Medication: _____ Reason: _____

The main office will store the following emergency medication(s) for the student for the following reasons:

Medication: _____ Reason: _____

Medication: _____ Reason: _____

The student has permission to self administer the following medication(s):

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

Under Wisconsin Statute Section 118.29, private schools are required to have permission from a medical provider to administer medications at school. School employees are hereby authorized to 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.

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

School Administrator Authorization: _____ Date: _____