LUMEN CHRISTI CATHOLIC SCHOOL
11300 N. St. James Lane
Mequon, WI 53092
(262) 242-7960

Parent/Guardian Non-Prescription Consent Form (Please print)

Full name of child: _____ DOB: _____ Grade:_____

Reason for medication:

_____

_____

As the parent/guardian of the above mentioned student, I give the school permission to administer the following medication(s) to my child for the reason listed above:

Medication/Dosage	Route (how it is to be given)	Frequency: How often	Start Date	Stop Date	Side Effects

As the parent/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 part of the Wisconsin Statute Chapter 118.29, schools are required to have permission from a parent/guardian to administer nonprescription 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. I agree to hold the School, its employees and agents who are acting within the scope of their duties harmless in any and all claim arising from the administration of this medication at school.

All medications must be in the original container listing the recommended therapeutic dosage. Administration of a dosage other than the recommended therapeutic dose may be given only if the written request to do so is also accompanied by the written approval of the child's medical provider.

Parent(s)/Guardian Name (please print): _____

Parent(s)/Guardian Signature: _____ Date: _____

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Medical Provider Prescription Authorization Form (Please print)

Full name of child: _____ DOB: _____ Grade:_____

Reason for medication:

_____

_____

Daily Medication

Medication	Dosage	Route	Frequency	Start Date	Stop Date	Side Effects

As needed of PRN Medication

Medication	Dosage	Route	Frequency	Start Date	Stop Date	Side Effects

Medical Provider Consent

I authorize the school to 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: _____ Phone: _____

Medical Provider Signature: _____ Date: _____

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: _____

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.