MILWAUKEE PUBLIC SCHOOLS

Department of Specialized Services
Nursing
6620 W. Capitol Dr.
Milwaukee, WI 53216
(414) 438-3648 • mps.milwaukee.k12.wi.us

MEDICATION and PROCEDURE PERMISSION AND INSTRUCTION FORM

Student's Name: ____ Student's ID #:______________

School: Fairview School__________ Grade: _________ Date of Birth: ________________

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.)

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Medical Provider Permission

Student's Name: ____ Student ID #:_________________
Assigned School: Fairview School Fax: 546-7715 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

Start. Stay. Succeed.
Comienza. Quédate. Triunfa.