KENOSHA UNIFIED SCHOOL DISTRICT

MEDICATION AUTHORIZATION FORM

SCHOOL NAME: _____ PHONE: _____ FAX: _____

ONE MEDICATION PER FORM

Medication to be administered as directed.
Student Name: _____ DOB: ____/____/_____
Medication: _____
Dosage: _____
Route: _____
Time(s) Administered: _____
Reason for Medication: _____
Student may carry medication for Emergency (LIFE SAVING) purposes only * EPINEPHRINE, RESCUE INHALER, GLUCAGON, INSULIN * : _____ Yes _____ No
Additional directions/symptoms: _____

Health Care Provider Signature: _____ Date: ____/____/_____
Health Care Provider Name (Please Print): _____
Address: _____ Phone: _____ Fax: _____

NOTE: Parent/Guardian signature permits designated school staff to dispense medication to the above student and to F R Q W D F W W K H K H D O W K F D U H S U R Y L G H U D W D Q \W DU På På PÁ• D W

Revised 10.15.20