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