West Allis West Milwaukee School District – 1205 South 70th Street, West Allis, WI 53214 – 414-604-3000

Medication Administration
Physician Ordered

School Name: _____

Student Name: _____ Date of Birth: _____

Parent Name: _____

Before prescription medication can be administered by designated school personnel, a signed statement/prescription from the physician including diagnosis, medication name, dosage, frequency, and possible side effects must be on file.

The following instructions for medication administration during school hours include:

Medication Name: _____

Medical Diagnosis: _____

Dosage: _____ Frequency/Administration Time: _____

Route: _____

Signs/Symptoms requiring administration if medication given on an as needed basis: _____

_____

Possible Side Effects to be Observed: _____

_____

Comments/Additional Instructions and/or Precautions: _____

_____

Physician Name: _____ Clinic Phone: _____

Physician Signature: _____ Date: _____

Note: This form may be faxed to the respective school upon completion or to the District Nursing Department at 414-546-5641. For questions call the District Nursing Department at 414-604- 4000 x 1107.