MILWAUKEE PUBLIC SCHOOLS

REQUEST TO DISCONTINUE MEDICATION ADMINISTRATION AT SCHOOL

Student Name	DOB	
School	ID #	
Parent/Guardian	Primary Contact #	Secondary Contact #
Emergency Contact	Primary Contact #	Secondary Contact #
School Nurse	Office #	Fax #
Nurse Signature		

Health Care Provider: We, the School Nurse, School Nurse Associate, or Unlicensed Authorized Personnel, have been unable to administer the scheduled medication during school hours for the named student due to the following:

Name of Medication: _____

Dosage: _____

- ☐ Parent has failed to provide medication since _____
- ☐ Student refusing to take medication since _____
- ☐ Change in medication schedule _____
- ☐ Date Parent/Guardian notified _____

For this reason, we are requesting that the order be discontinued at school. The Parent/Guardian has been notified. In the future, if medication administration during school hours becomes necessary, the following are required: updated *Medication/Procedure Authorization form with Parent Responsibilities for Administration of Medication at School* and the medication in a pharmacy labeled container.

Signature of Healthcare Provider _____ Date _____

Name of Healthcare Provider	Office #	Fax #
Healthcare Provider Address		