PORT WASHINGTON-SAUKVILLE SCHOOL DISTRICT

We educate all children to reach their greatest potential.

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AUTHORIZATION TO DISCONTINUE MEDICATION

Health Care Provider: The medication for the student below has changed. Please note the listed change and sign and fax the discontinue order back to school. Thank you.

Name of Student: _____
Date of Birth:_____

School: _____

Fax number: _____

School Nurse:_____

Name of Parent(s)/Guardian: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Name of Medication: _____

Dosage:_____

Date to Stop:_____

___Parent reports change of medication, new order form attached.

___Parent has failed to provide medication since: _____

___Student is no longer attending Port Washington-Saukville.

Name of Prescribing Medical Provider:

_____

Signature of Prescribing Medical Provider: _____

Date: _____

Health Care Provider Address:

_____

Health Care Provider's Phone Number: _____

Health Care Provider's Fax Number: _____

Parent/Guardian Signature: _____

Date: _____