To be updated by parent/guardian/physician annually

MEDICATION AUTHORIZATION FORM

_____ **SCHOOL,** _____**, ILLINOIS**

Student Name (Last, First, Middle)	Date of Birth	Grade	Date
_____	_____	_____	_____

Medications may be administered in school in accordance with the School Medication Procedures. No medication may be administered in school unless both the student's physician and parent/guardian have completed, signed, and returned this entire form to the School and the medication in the original labeled container as dispensed (**prescription** prescription medication) or the manufacturer's labeled container (n-prescription medication). The medication label shall contain the student's name, name of the medication, direction for use and date.

Parent/Guardian Permission and Authorization

I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School Principal or his/her designee, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer in accordance with School Medication Procedures), lawfully prescribed medication and non-prescribed medication in the manner described in the Physician's Order {Side 2}. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual who does not have medical training, and I specifically consent to such practices.

I understand that this authorization is not effective unless the School Principal or his/her designee has approved the medication authorization for my child and signed the approval form on Side 2.

I further acknowledge and agree that, when such medication is to be administered or attempted to be administered, I waive any claims I might have against the School, the Catholic Bishop of Chicago, the parish, or any of their employees or agents arising out of the administration or attempted administration of such medication. In addition, I agree to hold harmless and indemnify the School, the Catholic Bishop of Chicago, the parish, and its employees or agents, jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempted administration of said medication.

_____
Parent/Guardian (PRINT)

_____
Parent/Guardian (SIGNATURE)

_____
Address

_____
City, State, Zip Code

_____
Home Phone **Business Phone**
Cell Phone _____

_____
Parent/Guardian (PRINT)

_____
Parent/Guardian (SIGNATURE)

_____
Address

_____
City, State, Zip Code

_____
Home Phone **Business Phone**
Cell Phone _____

SIDE 1

Physician's Order

Student _____ Grade _____

_____ _____ _____

Medication/ Health Care Treatment Dosage Time(s) to be administered

_____ _____

Intended effect of this medication Expected side effects, if any

_____

List any other medications the student is taking

1) May student self-administer medication under supervision of school personnel who do not have medical training?

(Please circle) YES NO

2) For ASTHMA and ALLERGY CONDITIONS ONLY:
I certify that this student has been instructed in the use and self-administration of this medication and is capable of self-administering the medication independently and without supervision.

(Please circle) YES NO

3) I also request that this student be allowed to carry the above-described medication on their person during school hours and during school-related activities in order to facilitate the self-administration of the medication needed.

(Please circle) YES NO

Administration Instructions:

_____ _____

Physician's /Prescriber's Signature Date Signed

_____ _____

Physician's/ Prescriber's Name (PRINT) (PRINT) Emergency telephone number

_____

Address City, State, Zip Code

Medication Authorization approved or denied and signed this ____ day of _____20___,

(Please circle one of the above)

by _____ on behalf of _____,Illinois

Signature of Principal Name School City