

# MEDICATION AUTHORIZATION FORM

\_\_\_\_\_ SCHOOL, \_\_\_\_\_, ILLINOIS

\_\_\_\_\_  
Student's 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 the following to the School Principal or his/her designee:

- X Medical Authorization Form
- X Unsupervised Self-Administration Request Form (if the student is to carry and use medication on his/her own during school hours or during school activities)
- X Medication in the original labeled container as dispensed (Prescription medication) or the manufacturer's labeled container (Non-prescription medication). The medication label shall contain the student's name, name of the medication, direction for use and date.

## Physician's Order

\_\_\_\_\_  
Medication/ Health Care Treatment

\_\_\_\_\_  
Dosage

\_\_\_\_\_  
Time(s) to be administered

\_\_\_\_\_  
Intended effect of this medication

\_\_\_\_\_  
Expected side effects, if any

\_\_\_\_\_  
Other medications the student is taking

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

(Please circle) YES NO

Administration Instructions

\_\_\_\_\_

\_\_\_\_\_

Discontinue Re-evaluation Follow-up (Please Circle):

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's /Prescriber's Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Physician's/ Prescriber's Name

\_\_\_\_\_  
Emergency telephone number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

## Physician Request for Self-Administration of Medication

\_\_\_\_\_  
Name of Student

\_\_\_\_\_  
Date of Birth

To:

Principal, \_\_\_\_\_, School, \_\_\_\_\_, Illinois:

The above named child has \_\_\_\_\_  
Name of Illness or Medical Condition

I am requesting that the above-named student be allowed to take the following medication during school hours or during school-related activities:

\_\_\_\_\_  
Name of Medication

\_\_\_\_\_  
Type of Medication (tablet, liquid, capsule, inhaler, injectable)

\_\_\_\_\_  
Dosage

\_\_\_\_\_  
Time(s) to be taken or administered

\_\_\_\_\_  
Possible side effects

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. (Circle One):

Yes

No

For ASTHMA and ALLERGY CONDITIONS ONLY: 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 as needed. (Circle One):

Yes

No

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Physician

\_\_\_\_\_  
Address

\_\_\_\_\_  
Emergency telephone number

\_\_\_\_\_  
City, State

\_\_\_\_\_  
Last Name, First Name, MI

\_\_\_\_\_  
Grade

FOR OFFICE USE ONLY

### Medical Information and Emergency Notification Form

Academic Year \_\_\_\_\_

\_\_\_\_\_  
Student's name (Last Name, First Name, Middle Initial)

\_\_\_\_\_  
Date of Birth

I hereby acknowledge that I have received and read the School Medication Procedures. I understand that I am primarily responsible for all medical decisions regarding my child and that under the School Medication Procedures, and that the administration or self-administration of medication to my child will not be allowed unless I have complied with the requirements of the School Medication Procedures.

\_\_\_\_\_ has the following medical conditions:  
(Student's name)

In case of an emergency involving this student, please contact:

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
Daytime telephone

Other Emergency Contact:

\_\_\_\_\_  
Other telephone

\_\_\_\_\_  
Individual

\_\_\_\_\_  
Daytime telephone

\_\_\_\_\_  
Relationship to Student

\_\_\_\_\_  
Other telephone

X \_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
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 {Reverse side}. 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 this form in the space provided below.

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. In addition, I agree to hold harmless and indemnify the School, the Catholic Bishop of Chicago, the parish, and their employees or agents, either 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's Signature

signed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/ Guardian's Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Home telephone

\_\_\_\_\_  
Business telephone

Medication Authorization Approved this \_\_\_\_ day of \_\_\_\_\_, 200\_\_.

\_\_\_\_\_  
School Representative's Signature

On behalf of \_\_\_\_\_ School, \_\_\_\_\_, Illinois.