

MEDICATION AUTHORIZATION FORM

2021-22 - ST. PATRICK SCHOOL, WADSWORTH, 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 #

Address City, State Zip Code

Physician Request for Self-Administration of Medication

Name of Student Date of Birth

To:

Principal, Mrs. Mary Vitulli, School, St. Patrick 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 Phone Number

City, State, Zip

FILL OUT ONLY IF MEDICATION IS NEEDED.

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 medicine.

Parent/Guardian Signature

Date

Parent/Guardian Name (Please Print)

Address

City, State, Zip Code

Home Telephone Number

Business Telephone Number

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Medication Authorization Approved this date: _____

School Representative's Signature

On behalf of St. Patrick School, Wadsworth, Illinois.