To be updated by parent/guardian/physician annually

MEDICATION AUTHORIZATION FORM

	SCHOOL,		, ILLINOIS
Student Name (Last, First, Middle)	Date of Birth	Grad	le Date
Medications may be administered in so No medication may be administered in so have completed, signed, and returned the labeled container as dispensed (prescript prescription medication). The medicat medication, direction for use and date.	school unless both the stu is entire form to the Scho tion medication) or the m	ident's physic ool and the M nanufacturer's	cian and parent/guardian ledication in the original s labeled container (non-
Parent/Guardi	an Permission and A	uthorizatio	n
I hereby acknowledge that I am prima However, in the event that I am unable authorize the School Principal or his/hadminister to my child (or to allow my comproduces), lawfully prescribed medical in the Physician's Order {Reverse of administration of medications to my commedical training, and I specifically consort I understand that this authorization is not approved the medication authorization for I further acknowledge and agree that, we administered, I waive any claims I might parish, or any of their employees of administration. In addition, I agree to how Chicago, the parish, and their employees and all claims, damages, causes of action attempted administration of said medical	e to do so or in the even her designee, on my be child to self-administer in ation and non-prescribed side}. I acknowledge child to be performed be ent to such practices. It effective unless the School or my child and signed the or my child and signed the or agents arising out of old harmless and indemni- es or agents, either jointle on or injuries incurred or	nt of a medic half, to adm n accordance medication that it may y an individ hool Principa his form in the to be administ, the Catholic of the administ of the School by or severall	cal emergency, I hereby inister or to attempt to with School Medication in the manner described be necessary for the ual who does not have I or his/her designee has e space provided below. I or attempted to be to Bishop of Chicago, the nistration or attempted I, the Catholic Bishop of y, from and against any
Parent/Guardian (PRINT)	Par	ent/Guardian	(PRINT)
Parent/Guardian (SIGNATURE)	Par	ent/Guardian	(SIGNATURE)
Address	Ado	dress	
City, State, Zip Code	City	y, State, Zip C	ode
Home Phone Business Phone	Hon	ne Phone	Business Phone
Parent/Guardian (SIGNATURE) Address City, State, Zip Code	Par Ado	ent/Guardian dress y, State, Zip C	(SIGNATURE)

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	Physi	cian's (Order		
Student					Grade
Medication/ Health Care Treatment	Dosage	_		Time(s) to be a	dministered
Intended effect of this medication				Expected side e	ffects, if any
Other medications the student is tak	ing				
1) May student self-administ medical training?	ter medication u	nder sup	ervision o	of school personnel w	ho do not have
	Please circle)	YES	NO		
2) For ASTHMA and ALLE I certify that this student and is capable of self-adm	has been instruc	cted in th	e use and		
(Please circle)	YES	NO		
I also request that this stu during school hours and o of the medication as neede	during school-re				
(Please circle)	YES	NO		
Administration Instructions:					
DI : : 1 (D : :1 1 (C: : :				D . C . 1	
Physician's /Prescriber's Signature				Date Signed	
Physician's/ Prescriber's Name (PRI	NT)			Emergency telep	hone number
dress			City , State, Zip Code		
Medication Authorization ap	oproved or de	enied ar	nd signe	d this day o	f,
20, bys	Signature of Duino	inal			on behalf of
S	ngnature of Frinci				
		_Schoo	l,		, Illinois