To be updated by parent/guardian/physician annually

MEDICATION AUTHORIZATION FORM

St. Gerald SCHOOL, Oak Lawn, 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 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.

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 (PRINT)	Parent/Guardian (PRINT)
Parent/Guardian (SIGNATURE)	Parent/Guardian (SIGNATURE)
Address	Address
City, State, Zip Code	City, State, Zip Code
Home Phone Business Phone	Home Phone Business Phone

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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

_____

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

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.

(Please circle) YES NO

Administration Instructions:

_____ _____

Physician's /Prescriber's Signature Date Signed

_____ _____

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

_____ _____

Address City , State, Zip Code

Medication Authorization approved or denied and signed this ____ day of _____,
(Please circle one)

20 ___, by _____ on behalf of
Signature of Principal

_____School, _____ , Illinois