To be updated by parent/guardian/physician annually

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 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 {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's Signature (PRINT)**	_____ **Parent/Guardian's Signature (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**
Cell Phone _____	**Cell Phone** _____

SIDE 1

To be updated by parent/guardian/physician annually

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 as needed.**

(Please circle) YES NO

Administration Instructions:

Administration Instructions:

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

_____ _____

Physician's /Prescriber's Signature **Date Signed**

_____ _____

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

_____

Address **City , State, Zip Code**

SIDE 2

Medication Authorization approved or denied and signed this ____ day of _____, 20___,
(Please circle one of the above)

by _____ **on behalf of** _____,
Signature of Principal **Name of School, City,** _____, **Illinois**

TO BE PUBLISHED IN THE SCHOOL/PARENT HANDBOOK
OR
TO BE DISTRIBUTED TO SCHOOL FAMILIES ANNUALLY AND TO NEW FAMILIES AT REGISTRATION

OFFICE OF CATHOLIC SCHOOLS
ARCHDIOCESE OF CHICAGO

MEDICATION PROCEDURES IN SCHOOLS

Parents/guardians have the primary responsibility for the administration of medication to their children. The administration of medication to students during regular school hours and during school-related activities is discouraged unless necessary for the critical health and well-being of the student. Teachers, administrators and administrative staff shall not administer medication to students except as provided in these School Medication Procedures.

Procedures

1. **Administration.** No school personnel shall administer any prescription or non-prescription medicine unless the School has the student's current and complete **Medication Authorization Form** approved and signed by the School Principal.

   A **Medication Authorization Form** is distributed for each student at the beginning of each school year or enrollment of a new student during the year. The **Medication Authorization Forms** are available in the school office.

   To be published in the School Family Handbook

   The School retains the right to deny requests to administer medication to the student provided that such denial is indicated on the Medication Authorization Form. If the School denies a request and authorization for the administration of medication, parents/guardians must make other arrangements for the administration of medication to students, such as arranging for medication to be administered before or after school or having the parent/guardian or designee administer the medication in school.

2. **Self-Administration.** A student may self-administer medication at school if so ordered by his or her prescriber per the student's current and completed **Medication Authorization Form.** Students who suffer from asthma, allergies or other conditions that require the immediate use of medication shall be permitted to carry such medication and to self-administer such medication without supervision by school personnel only if the School has on file for the student a current and completed **Medication Authorization Form.** Otherwise, such medication must be stored in a locked cabinet under the control of the School and made available for the student to self-administer in accordance with the student's **Medication Authorization Form**.

OFFICE OF CATHOLIC SCHOOLS
ARCHDIOCESE OF CHICAGO

MEDICATION PROCEDURES IN SCHOOLS

3. **Appropriate Containers.** It is the responsibility of the parent/guardian to provide the School with all medication in appropriate containers that are:

    a. **Prescription – labeled by a pharmacy or licensed prescriber (displaying Rx number, student name, medication, dosage, direction for administration, date and refill schedule, pharmacy label, and name/initials of pharmacist) OR**

    b. **Manufacturer – labeled for non-prescription over-the-counter medication.**

4. **Storage of Medication.** Medication received by the School in accordance with a completed **Medication Authorization Form** and in an appropriate container shall be stored in a locked cabinet. Access to the locked cabinet shall be limited to the School Principal, his/her designees, and the school nurse (if applicable).

    Medication requiring refrigeration shall be stored in a refrigerator that cannot be accessed by students and shall be kept separate from food items.

    At the end of the school year, or at the end of the treatment regime, the student's parent/guardian will be responsible for removing any unused medication from the school. If the parent/guardian does not pick up the medication by the end of the school year, the School will appropriately discard the medication.

Archdiocese of Chicago Office of Catholic Schools
To be completed by parent/guardian for each child and submitted to the school annually.

MEDICAL AND EMERGENCY NOTIFICATION INFORMATION
AUTHORIZATION FOR MEDICAL TREATMENT

SCHOOL _____ SCHOOL YEAR _____

STUDENT NAME	DATE OF BIRTH	GRADE	LIST MEDICAL ALLERGIES and/or SIGNIFICANT MEDICAL HISTORY

PLEASE PRINT

Parent/Guardian_____ Parent/Guardian_____

Home Phone ( ) _____ Work ( ) _____ Home Phone ( ) _____ Work ( ) _____
Cell Phone ( ) _____ Cell Phone ( ) _____

Name of Student's Physician _____ Phone ( )_____

Address _____ City _____ State _____

Medical Insurance Provider_____ Policy/Insurance # _____

EMERGENCY CONTACTS IN CASE PARENT/GUARDIAN CANNOT BE REACHED:

NAME _____ RELATIONSHIP TO STUDENT _____
Phone 1 ( ) _____ Phone 2 ( ) _____

NAME _____ RELATIONSHIP TO STUDENT _____
Phone 1 ( ) _____ Phone 2 ( ) _____

MEDICAL RELEASE

In the event that the undersigned, or my/our authorized physician, cannot be reached and in the judgment of the School Principal or his/her authorized staff member, there is a necessity for immediate examination and/or treatment of my/our child, I/we hereby request and authorize any of the aforesaid personnel to obtain for my/our child such medical services as are deemed necessary. I/We agree to assume the financial responsibility for any diagnosis/treatment and/or for medication deemed necessary. I/We understand that it may be necessary for my/out child's medical condition to be disclosed to school personnel and/or medical providers and I/We expressly consent to such disclosure.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

THIS FORM SHALL ACCOMPANY STUDENTS ON FIELD TRIPS. IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO UPDATE EMERGENCY INFORMATION AS NECESSARY.