SCHOOL MEDICATION AUTHORIZATHON FORM

St. Mary School
1416 Main St.
Mt. Vernon, IL 62864
618-242-5353

SCHOOL MEDICATION AUTHORIZATION

PART 1

PART 1 must be completed and signed by the child's physician or prescriber:

CHILD'S NAME____

NAME OF MEDICATION____

DOSAGE_______FREQUENCY______TIME TO BE GIVEN IN SCHOOL________________

DATE OF PRESCRIPTION________DATE OF ORDER_______________________________

DISCONTINUANCE DATE____

DIAGNOSIS REQUIRING MEDICATION____

INTENDED EFFECT OF THIS MEDICATION______________________________________

SIGNIFICANT SIDE EFFECTS IF ANY____

TIME INTERVAL FOR RE-EVALUATION____

OTHER MEDICATION CHILD IS RECEIVING______________________________________

THIS MEDICATION MUST BE ADMINISTERED DURING THE SCHOOL DAY (between the hours of 8:00 a.m. and 4:00 p.m.) IN ORDER TO ALLOW THE CHILD TO ATTEND SCHOOL.
YES___________ NO__________

THIS MEDICATION MAY BE ADMINISTERED BY NON-MEDICALLY TRAINED SCHOOL TEACHERS.
YES__________ NO__________

THE CHILD MAY SELF-MEDICATE HIM/HER SELF.
YES__________ NO__________

PHYSICIAN'S SIGNATURE (required) DATE

Medication must be brought to school by the parent in a container appropriately labeled by the pharmacy or the physician/prescriber. Medication orders should be renewed annually for long-term medications and any changes should be reported to the school nurse in writing.

SCHOOL MEDICATION AUTHORIZATION

PART 2

PART 2 must be completed by the child's parent. PLEASE PRINT.

CHILD'S NAME______________________________BIRTH DATE_______________

ADDRESS___________________________________HOME PHONE______________

SCHOOL____________________________________TEACHER__________________

PARENTS' EMERGENCY PHONE NO______________________________________

PHYSICIAN/PRESCRIBER'S NAME____

PHYSICIAN/PRESCRIBER'S ADDRESS_____________________________________

PHYSICIAN/PRESCRIBER'S OFFICE AND EMERGENCY PHONES_____________

I herby confirm 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 **St. Mary Catholic School, 1416 Main St**. and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described in Part 1 of this form.

I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATIONS TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE AND SPECIFICALLY CONSENT TO SUCH PRACTICES.

I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agent arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School district, its employees and 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 attempts at administration of said medication.

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PARENT'S SIGNATURE (required) DATE

FOR OFFICE USE ONLY

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PERSON OBTAINING PERMISSION BY PHONE DATE TIME

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PERSON GRANTING PERMISSION BY PHONE