ST. VINCENT DE PAUL

CATHOLIC SCHOOL

School Medication Authorization Form

To be completed by the student's parent/guardian. A new form must be completed each school year. Please complete one form per medication. Medications must be brought to the school office in the original container.

Student's Name: ___________________________________ Birthdate: __________________

Address: ____

Home Phone: ____________________________ Cell Phone: ____________________________

To be completed by the student's physician.

Physician's Name (printed): ____

Office Address: ____

Office Phone: ____

Medication Name: ____

Purpose of Medication: ____

Dosage: ____________________________________ Frequency: ________________________

Time medication is to be administered at school or under what circumstances: ______________

____

Prescription Date: _______________________________ Order Date: ______________________

Discontinuation Date: ____

Expected Side Effects (if any): ____

Other medications student is receiving: ____

Physician's Signature: ____ Date: ______________

Parents must also complete the next page

For all parents/guardians:
By signing below, I agree 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 ___________________ and its employees and agents, on my behalf, 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 ____________), lawfully prescribed medication in the manner described above, or over-the-counter medication that has been brought in by the student in the manner indicated on the container.

I acknowledge that _______________ does not have a school nurse. I agree to indemnify and hold harmless ________________and its employees and agents against any and all claims, except a claim based on willful and wanton misconduct, arising out of the administration or the child's self-administration of medication.

If you agree, please initial: _____________
Parent/guardian

For parents/guardians of students who need to carry asthma or diabetes medication or an epinephrine auto-injector:
I authorize _________________ and its employees and agents, to allow my child to possess and use his/her asthma or diabetes medication and/or epinephrine auto-injector while in school. Illinois law requires _______________ to inform parents/guardians that it, and its employees and agents, incur no liability, except for willful and wanton misconduct, as a result of any injury arising from a student's self-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30).

If you agree, please initial: _____________
Parent/guardian

All parents must sign below:

________________________________	________________________________
Printed name	Printed name
________________________________	________________________________
Signature/Date	Signature/Date