

To be updated by parent/guardian/physician annually

### MEDICATION AUTHORIZATION FORM

\_\_\_\_\_ SCHOOL, \_\_\_\_\_, 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