

** This page is needs to be filled out for each child **

GRADE _____

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. 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 I 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's Signature

Signed Date

Parent / Guardian's Name

Address

City, State, Zip Code

Home telephone

Business telephone

Medication Authorization Approved this _____ day of _____, 200__.

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School Representative's Signature

On behalf of Sacred Heart School, Melrose Park, Illinois

** This page needs to be filled out if your child needs medicine administered at School. **

MEDICATION AUTHORIZATION FORM

Sacred Heart School, Melrose Park, 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 the following to the School Principal or his/her designee:

- X Medical Authorization Form
- X Unsupervised Self-Administration Request Form (if the student is to carry and use medication on his/her own during school hours or during school activities)
- X 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.

Physician's Order

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

May student self administer medication under supervision of school personnel who do not have medical training Yes No

Administration Instructions: _____

Discontinue Re-evaluation Follow-up (Please circle) _____
Date

Physician's / Prescriber's Signature Date Signed

Physician's / Prescriber's Name Emergency telephone number

Address: _____
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Medication Authorization Approved this _____ day of _____, 200__.

School Representative's Signature

On behalf of Sacred Heart School, Melrose Park, Illinois.

**** This page needs to be filled out if your child needs medicine administered at School. ****

Physician Request for Self-Administration of Medication

Name of Student

Date of Birth

To:
Principal, Sacred Heart School, Melrose Park, Illinois:

The above named child has _____

I am requesting that the above-named student be allowed to take the following medication during school hours or during school-related activities:

Name of Medication Type of Medication(tablet, liquid, capsule, inhaler, injectable)

Dosage Time(s) to be taken or administered

Possible Side effects

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 (Circle one): Yes No

For ASTHMA and ALLERGY CONDITIONS ONLY: 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. (Circle one) Yes No

Physician's Signature

Date signed

Physician's Name

Emergency telephone number

Address: _____