SAINT PATRICK
HIGH SCHOOL

Faith. Tradition. Brotherhood.

To be updated by Parent/Guardian/Physician annually
MEDICATION AUTHORIZATION
Saint Patrick High School, Chicago, 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 (nonprescription 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 nurse or other administration 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 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, 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 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 (PRINT)

______________________________ Parent/Guardian (SIGNATURE)

______________________________ Address

______________________________ City, State, Zip Code

______________________________ ______________________________
Home Phone Business Phone

____
Cell Phone

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 needed.
(Please circle) YES NO

Administration Instructions

Physician's/Prescriber's Signature

Date Signed

Physician's/Prescriber's Name (PRINT)

Address

City, State, Zip Code

Emergency Telephone Number