ST. ANTHONY GRADE SCHOOL - Effingham, IL

Doctor's Medication Authorization Form

To be completed by the child's parent(s)/guardian(s) and kept in the school nurse's office or in the Principal's office.

Student's Name ____ Birthdate ______________

Address ____

Home Phone: ______________________________ Emergency Phone: ____________________

To be completed by the student's physician:

Physician's Printed Name ____

Office Address: ____

Office Phone: ________________________________ Emergency Phone: __________________

Medication: ____

Dosage: ___________________________________ Frequency: __________________________

Time medication is to be administered or under what circumstances: ______________________

____

Method of Administration ____________________________ Discontinuation Date ___________

Diagnosis requiring medication: ____

Intended effect of this medication: ____

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition? ____ Yes ____ No

Expected side effects, if any: ____

Time interval for re-evaluation: ____

Other medications student is receiving: ____

__________________________________	______________________________	__________
Physician's printed name	Physician's Signature	Date

PARENT: SEE REVERSE SIDE

THIS SECTION TO BE COMPLETED BY PARENT(S)/GUARDIAN

I/We, the undersigned parent(s)/guardian(s) of the minor child, ___________________________, a student at St. Anthony Grade School, hereby request St. Anthony Grade School to allow said child to attend school in spite of a special health problem and to be given medication prescribed as directed by physician on reverse side of this form under the supervision of school personnel.

The medicine is to be furnished by me and labeled by the physician or pharmacist with said child's name, doctor, and drug store, name of drug, and the specific time it is to be given at school. I/We assume all responsibility for any mistake in furnishing an incorrect dosage.

For and in consideration of allowing said child to attend school in spite of this special problem, we hereby release, relieve and discharge St. Anthony Grade School and/or any of its agents or employees, from any and all liability for any injury or damage to the health of said child arising out of, or resulting from the necessity of said child having to take medication during school hours.

I/We have read, understand and agree to the school's regulations concerning giving medication at school.

Parent's Signature ____ Date _____________

Address ____

Telephone Number ____

For Parent(s)/Guardian(s) of Students who have asthma and/or severe allergy:

(Parent/Guardian signature required for student to carry and self-administer asthma medication or epinephrine auto-injector)

I authorize the school district and its employees and agents to allow my child or ward to possess and use his/her asthma medication or epinephrine auto-injector (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school operated property. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication (105 ILSC 5/22-30).

If you agree please sign: ____
Parent(s)/Guardian(s) Signature

Date _____________________