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Christ Our Cornerstone

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**NEWMAN CENTRAL CATHOLIC HIGH SCHOOL**

1101 WEST 23RD STREET  
STERLING, ILLINOIS 61081-9002

**School Medication Authorization Form for Students**

To be completed by the child's parent(s) guardian(s) and kept in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

**To be completed by the student's physician:**

\*Physician's Printed Name: \_\_\_\_\_

\*Office Address: \_\_\_\_\_

\*Office Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Non-Prescription: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Time medication is to be administered or under what circumstances: \_\_\_\_\_

Prescription Date: \_\_\_\_\_ Order Date: \_\_\_\_\_ Discontinuation Date: \_\_\_\_\_

Diagnosis requiring medication: \_\_\_\_\_

Intended effect of this medication/Side Effects, if any: \_\_\_\_\_

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 \_\_\_\_\_

Time interval for re-evaluation: \_\_\_\_\_

Other medication student is receiving: \_\_\_\_\_

Healthcare Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

**"Neither the school nor school personnel incur liability for injury or illness or other damage resulting from administering medication prescribed by a licensed physician or other licensed medical personnel, and administered in accordance with the prescribed dosage."**

**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 in the event of a medical emergency, I hereby authorize the School District and its employees and agents, in my behalf and stead, to administer or attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a nurse, and specifically consent to such practices;** and to indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the pupil.

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**For parent(s)/guardians(s) of students who self-administer medications:** I authorize the School District and its employees and agents, to allow my child or ward to possess and use his or her asthma medication, epinephrine auto-injector or medical cannabis (1) while in school, (2) while at 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 (105ILCS 5/22-30).

If you agree please sign \_\_\_\_\_ Date \_\_\_\_\_