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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**______________________

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 or epinephrine auto-injector (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, expect 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**______________________

Parent(s)/Guardian(s) Signature