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 {Reverse side}. 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 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 Date

____

Parent/Guardian's Name

____

Address

____

City, State, Zip Code

____

Home Telephone

____

Business Telephone

(To be complete by School)

Medication Authorization Approved this ________day of _____________, 20___.

____

School Representative's Signature

On behalf of Saint Bede School, Ingleside, Illinois

MEDICATION AUTHORIZATION FORM

Saint Bede School, Ingleside, 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 Medication 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?

(Please circle) YES NO

Administration Instructions
____

____
____

(Please Circle): Discontinue Re-evaluation Follow-up on ____________________

Date

_ _

____

Physician's Signature Date Signed

_ _

____

Physician's Name Emergency telephone number

_ _

____

Address City, State, Zip Code