AACA
ALPHONSUS
1439 W. Wellington Ave
Chicago, IL 60657
773-348-4629 PH
773-348-4829 FAX

MEDICATION AUTHORIZATION FORM

This form must be returned to the Nurse's Office. A physician's order is necessary for ANY MEDICATION, over-the-counter, short-term and long-term medication. We **CANNOT** and **WILL NOT** administer the medication without it.

THE FOLLOWING MUST BE COMPLETED BY THE PARENT/GUARDIAN:

Students Name_____ Teacher_____ Grade____ Room #_____

Address_____ Phone Number_____

Birthdate_____ Other medications the child is taking_____

_____I hereby request and grant permission to the authorized personnel from the above named school to administer the medication described on this form to my child.

_____I give permission for my child to carry his/her inhaler and to be responsible in its use provided the doctor gives consent for same. I also give permission for my child to self administer his/her medication when s/he is on a field trip. If there are any questions, please contact your child's school nurse.

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. In addition, I agree to hold harmless and indemnify the school, the Catholic Bishop of Chicago, the parish and their employees, either jointly or severally, from and against any and all claims, damages, and causes of action or injuries incurred or resulting from the administration or attempted of said medication.

Parent/Guardian Signature_____ Date_____

Work Phone (____)_____Cell Phone (____)_____Emergency Phone (____)_____

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THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN:

Physicians Name (please print) _____Phone Number (____)_____

Physicians Address_____ City_____ Zip_____

Illness/Condition Involved_____

MEDICATION_____

Dosage _____Time to be given_____Duration of the dosage_____

MEDICATION_____

Dosage_____ Time to be given_____Duration of the Dosage_____

Possible Side Effects_____

_____The above named student may self-administer his/her medication on a field trip. I certify that s/he has been properly instructed in its use.

_____The above named student may carry and self-administer his inhaler. I certify that s/he has been properly instructed in its use.

Physicians Signature_____ Date_____

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IMPORTANT INFORMATION

1. The medication must be brought in proper containers and labeled appropriately, (please refer to Instructions for Providing Medications for School handout enclosed)
2. The parent MUST report immediately any changes in prescription or dosage. New doctor's orders must be obtained for each change and all medication permission must be renewed at the beginning of each school year.
3. Medication and permission form will be kept in the Nurse's Office.