MEDICATION AUTHORIZATION FORM

St. Joseph School, Downers Grove, Il 60515

_____ _____ _____ _____

Student's Name (Last, First, Middle) Date of Birth Grade/Room Number 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:

- ☐ **Medical Authorization Form**
- ☐ **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)
- ☐ **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 ☐ Yes ☐ No

Administration Instructions:_____

_____

Discontinue Re-evaluation Follow-up (Please circle) _____
Date

_____ _____
Physician's / Prescriber's Signature Date Signed

_____ _____
Physician's / Prescriber's Name Emergency telephone number

Address: _____

Medication Authorization Approved this _____ day of _____, 20___.

_____
School Representative's Signature (On behalf of St. Joseph School, Downers Grove, Il)

Physician Request for Self-Administration of Medication

_____ _____

Name of Student Date of Birth

To: Principal, St. Joseph School, Downers Grove, Il.:

The above named child has _____

I am requesting that the above-named student be allowed to take the following medication during school hours or during school-related activities:

_____

Name of Medication Type of Medication (tablet, liquid, capsule, inhaler, injectable)

_____

Dosage Time(s) to be taken or administered

_____

Possible Side effects

I certify that this student has been instructed in the use and self-administration of this medication and is capable of self-administering the medication independently and without supervision (Circle one):

Yes No

For ASTHMA and ALLERGY CONDITIONS ONLY: I also request that this student be allowed to carry the above-described medication on their person during school hours and during school related activities in order to facilitate the self-administration of the medication as needed. (Circle one):

Yes No

_____ _____

Physician's Signature Date signed

_____ _____

Physician's Name Emergency telephone number

Address: _____