To be updated by parent/guardian/physician annually

MEDICATION AUTHORIZATION AND WAIVER FORM

_____**SCHOOL,**_____**, ILLINOIS**

_____	_____	_____	_____
Student's Name (Last, First, Middle)	Date of Birth	Grade	Date

Medications (both prescription and non-prescription) may be administered in school (including school trips) only 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 this entire form to the School and provided the 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. Prior to enrollment, or as soon as the condition is diagnosed, parents of any student diagnosed with Asthma, Diabetes, or Food Allergies, must coordinate with the school and your student's physician to provide a completed Asthma Action Plan, Diabetes Care Plan, and/or Illinois Food Allergy Emergency Action Plan and Treatment Authorization Form, as applicable.

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, or if the medication must be administered during the school day or during a school trip, I hereby authorize the School Principal or his/her designee, on my behalf, to administer (or to allow my child to self-administer in accordance with School Medication Procedures), medication in the manner described in the Physician's Order {Side 2}. 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 by signing this document, I, on behalf of myself and my child, am waiving and releasing any and all claims for injury that my child might sustain as a result of the administration of medication in school property or under the supervision of school personnel.

I understand that this authorization is not effective unless the School Principal or his/her designee has reviewed and signed this form.

In consideration for agreeing to administer, or oversee the administration of, my child's medication, I, on behalf of myself and my child, heirs, executors, agents and assigns, hereby agree to waive, relinquish, release, indemnify, hold harmless, and covenant not to sue the Catholic Bishop of Chicago, an Illinois corporation sole, _____ School, and their administrators, employees, agents, representatives, volunteers, insurers, assigns and successors ("Indemnitees"), from and against any and all claims, charges, demands, suits, and causes of actions, whether known or unknown, past, present or future, including, but not limited to, any and all costs, expenses, and attorneys' fees, by reason of any injury, illness, death, and damage or loss to person or property, or any other harm to myself or to any person or property, whether caused by negligence or for any other reason, arising out of, in connection with, or in any manner related to the administration of medication.

I INTEND BY MY SIGNATURE TO PROVIDE A COMPLETE AND UNCONDITIONAL WAIVER OF CLAIMS AND RELEASE OF LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW. I HAVE CAREFULLY READ THIS AUTHORIZATION AND WAIVER FORM, FULLY UNDERSTAND ITS CONTENTS, AND SIGN THIS AGREEMENT FREELY AND VOLUNTARILY.

_____	_____
Parent/Guardian's Signature (PRINT)	**Parent/Guardian (SIGNATURE)**
_____	_____
Parent/Guardian's Signature (PRINT)	**Parent/Guardian (SIGNATURE)**
_____	_____

Address

_____

City, State, Zip Code

_____

Home Phone Business Phone

_____

Cell Phone

Address

_____

City, State, Zip Code

_____

Home Phone Business Phone

_____

Cell Phone

January 2022

Handbook for School Administrators

MEDICATION AUTHORIZATION FORM

To be updated by parent/guardian/physician annually

Physician's Order

Student_____Grade_____

_____

Medication/Health Care Treatment Dosage Time(s) to be administered

_____

Intended effect of this medication Expected side effects, if any

_____

List any other medications the student is taking

1) **May student self-administer medication under supervision of school personnel who do not have medical training?**
   (Please circle) YES NO

2) **For ALLERGY CONDITIONS ONLY;**
   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. I have reviewed and signed the student's Illinois Food Allergy Emergency Action Plan and Treatment Authorization Form, if the nature of the student's allergies requires.

   (Please circle) YES NO

3) **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.**

   (Please circle) YES NO

4) **For ASTHMA MEDICATIONS ONLY: I have assisted in the development of an Asthma Action Plan to help control the student's asthma as needed. I have ensured that the student has been instructed in the use and self-administration of asthma medication and is capable of self-administering asthma medication independently and without supervision.**

   (Please circle) YES NO

5) **FOR DIABETES MEDICATIONS ONLY: I have provided instructions concerning the student's diabetes management during the school day, and any other information necessary to complete a diabetes care plan, including a copy of the signed prescription, methods of insulin administration, and a uniform record of glucometer readings.**

   (Please circle) YES NO

Administration Instructions:

Administration Instructions:

Discontinue Re-evaluation Follow-up (Please Circle): _____
Date

_____ _____

Physician's /Prescriber's Signature Date Signed

_____ _____

Physician's/ Prescriber's Name (PRINT) Emergency telephone number

_____ _____

Address City, State, Zip Code

Medication Authorization approved or denied and signed this_____day of_____, 20_____,

By_____on behalf of _____,

Signature of Principal Name of School, City, _____Illinois