

QUEEN OF PEACE HIGH SCHOOL
AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION AND
OVER THE COUNTER MEDICATIONS

To Parent or Guardian:

Our school policy states that all prescription and non-prescription medications that need to be taken during school hours must have this form completed in its entirety prior to the administration of medication. Medication should ideally be taken at home before or after school. However, if it is necessary for your daughter to take medication during school hours, please read and complete this form and present to your physician for completion. No medication will be given unless absolutely necessary for the critical health and well-being of the student.

ALL MEDICATIONS IN SCHOOL MUST BE:

1. *In the original prescription bottle or, for non-prescription medication in the original manufacturer's package;*
2. *Properly labeled with the name of the student, the prescribing physician, pharmacy name, name of medication, dosage, route and time to be taken;*

This medication form must be completed and include physician **and** parent/guardian signature and returned to the principal or her designee. The medication must be packaged properly as outlined above or the medication will not be given. One form for each prescribed medication must be filled out. **This form expires at the end of each school year or on the discontinuation date (if sooner) as indicated by the physician.** Thank you for your cooperation.

Medication Orders on prescription pads are not sufficient, this form must be completed.

Student

Name _____ ID# _____ Birthdate _____

PHYSICIAN ORDER: (completed by an Illinois licensed prescriber. One form per medication)

Name of Medication/Treatment _____ Date prescribed _____

Diagnosis requiring medication _____

Reason medication must be given during school hours _____

Intended effect of medication _____

Dosage _____ Time of administration _____ Route of administration _____

Student to self administer (circle one) Yes No **Physician initial** _____ **Parent initial** _____

Student is capable of self-administration and education has been given to this student by _____

May Student self-administer medication under the supervision of school personnel who do not have medical training? Yes No

Expected/Possible effects from medication _____ Intended effect _____

Discontinuation Date _____ Follow up visit scheduled yes no Date _____

Administration Instructions:

Physician's Signature **Date**
(Required)

Physician's Professional Stamp
(Required)

For **ASTHMA** and **ALLERGY CONDITIONS ONLY:** I also request that this student be allowed to carry the above described medication on her person during school hours and during school related activities in order to facilitate the self-administration of the medication needed. Yes No

I hereby acknowledge that I have received and read the School Medication Procedures. I understand that I am primarily responsible for all medical decisions regarding my child, and that the administration or self administration of medication to my child will not be allowed unless I have complied with the requirements of the School Medication Procedures. I understand that this authorization is not effective unless the School Principal or her designee has approved the medication authorization for my child and signed this form.

Parent Signature _____ **Phone Number** _____

Today's Date _____

over, please

Student Name _____ **ID#** _____ **Birthdate** _____

PARENT/GUARDIAN PERMISSION AND AUTHORIZATION

I hereby acknowledge that I am primarily responsible for administrating 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 her designee, on my behalf, to administer or attempt to administer to my child (or to allow my child to self-administer in the accordance with the School Medication Procedures) lawfully prescribed medication and non-prescription 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 further acknowledge and agree that when a lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against Queen of Peace High School or its employees arising out of the administration or attempted administration of any medications. I agree to indemnify and hold Queen of Peace High School, its officers, directors, members and employees harmless against any and all claims for loss/liability, damage or injury, including attorney fees arising out of, connected with, or resulting in part or whole from the administration or attempted administration of said medication.

Parent/Guardian Signature Date _____

Print Parent/Guardian Name

Address City State Zip Code

Home Telephone Cell Phone Work Phone

Medication Authorization approved _____
Date

School Representative's Signature _____ **Date** _____

On behalf of Queen of Peace High School, Burbank, Illinois