ST. VINCENT DE PAUL CATHOLIC SCHOOL

AUTHORIZATION TO DISPENSE MEDICATION FORM

TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN:

Note: A new form must be completed each school year. Please complete one form per medication. Medications must be brought to the school office in the original container.

Student's Name: _____ Birthdate: _____

Address: _____

Home Phone: _____ Cell Phone: _____

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN:

Physician's Name (printed): _____

Office Address: _____

Office Phone: _____

Medication Name: _____

Purpose of Medication: _____

Dosage: _____ Frequency: _____

Time medication is to be administered at school or under what circumstances:

_____

Prescription Date: _____ Order Date: _____

Discontinuation Date: _____

Expected Side Effects (if any): _____

Other medications student is receiving: _____

Physician's Signature: _____ Date: _____

Parents must also complete the next page

For all parents/guardians:

By signing below, I agree 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 St. Vincent de Paul Catholic School and its employees and agents, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of St. Vincent de Paul Catholic School), lawfully prescribed medication in the manner described above, or over-the-counter medication that has been brought in by the student in the manner indicated on the container.

I acknowledge that St. Vincent de Paul Catholic School does not have a school nurse. I agree to indemnify and hold harmless St. Vincent de Paul Catholic School and its employees and agents against any and all claims, except a claim based on willful and wanton misconduct, arising out of the administration or the child's self-administration of medication.

If you agree, please initial: _____
Parent/guardian

For parents/guardians of students who need to carry asthma or diabetes medication or an epinephrine auto-injector:
I authorize St. Vincent de Paul Catholic School and its employees and agents, to allow my child to possess and use his/her asthma or diabetes medication and/or epinephrine auto-injector while in school. Illinois law requires St. Vincent de Paul Catholic School to inform parents/guardians that it, and its employees and agents, incur no liability, except for willful and wanton misconduct, as a result of any injury arising from a student's self-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30).

If you agree, please initial: _____
Parent/guardian

All parents must sign below:

_____ _____
Printed name Printed name

_____ _____
Signature/Date Signature/Date