Holy Cross School
410 W. White Street
Champaign, IL 61820

SY23-24

PERMISSION TO SELF-MEDICATE AT SCHOOL

_____ needs to self-medicate during the school day.
(Student's Name)

Diagnosis: _____

Name of Medication: _____

Dosage: _____

When to be given: _____

Effective Date: From: _____ To: _____

Attending Physician: _____

Parent/Legal Guardian Signature: _____

Date: _____

All medication must be in the original packaging with the correct labeling (student's name, name of medication, correct dosage). All medications will be kept in the School Office and the student will come to the school office to receive their dosage at the correct time of the day or when they need the medication.

This form is for Over The Counter medications ONLY.
Please fill out a Prescription Medication Authorization From 2023-2024 for any doctor prescribed medications