Holy Cross School SY23-24
410 W. White St.
Champaign, IL 61820

# School Medication Authorization Form

*To be completed by the student's parent/guardian. 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***

Holy Cross School SY23-24
410 W. White St.
Champaign, IL 61820

**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 _____ 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 _____), 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 _____ does not have a school nurse. I agree to indemnify and hold harmless _____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 _____ 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 _____ 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