ST. TERESA CATHOLIC SCHOOL

1108 LEBANON AVENUE
BELLEVILLE, IL 62221

SCHOOL MEDICATION AUTHORIZATION FORM

Student Name (printed) _____ Grade _____

Any student who is REQUIRED to take medication of any kind during the school day may be assisted by the school nurse or other designated school personnel if the school has received the following:

1. A written statement from the physician detailing the method, amount, and time the medication is to be taken,
2. A written statement from the parent/guardian requesting the school to assist the pupil in the manner set forth by the physician statement, and
3. The medication shall be in a properly labeled pharmacy bottle.

A new form must be completed for all medication changes, or if the medication is discontinued sooner than stated below. All medication must be kept in and dispensed from the nurses' office.

PHYSICIAN STATEMENT

Student Name (printed) _____ Grade _____ Date _____

Name of Medication _____

Dosage _____ Time of Administration _____

Method of Administration _____ Date to Discontinue _____

Predictable Side Effects _____

Contraindications _____

Physician's Signature _____ Telephone Number _____

Street Address: _____

City: _____ State: _____ Zip: _____

PARENT OR GUARDIAN STATEMENT

As the parent/guardian of the above named student, I request St. Teresa School to assist in carrying out the physician's instructions in the administration of the above named medication during the school day. I further agree that when the medication is so administered, I waive any claims I might have against the school, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the school, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of said medication.

I have read the policy and procedures for administration of medication at St. Teresa School and agree to abide by them.

Parent Signature: _____

Parent Name (printed): _____

Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Please return this form to the school office, signed by the physician and the parent/guardian.

NO MEDICATION (PRESCRIPTION OR OVER-THE-COUNTER) WILL BE ADMINISTRED WITHOUT REQUIRED SIGNATURE