ST. PAUL
CATHOLIC SCHOOL
Odell, IL
300 S. West St. - 60460
815.998.2194 (p) 815.998.1514 (f)
schooloffice@saintpaulodell.com

Date:_____

Medication Authorization Form 2023-2024

This form is required for **both prescription and over-the-counter medication.** Please complete one form per medication. Medications must be brought to the school office in the original container. Parents MUST provide the school with all medications.

Student's Name: _____ Birth Date: _____

Address: _____

Parent Name: _____ 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: _____

Other side MUST be signed by both parents.

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Medication Authorization Form 2023-2024

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. PAUL 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. PAUL SCHOOL), lawfully prescribed medication in the manner described by their doctor, or over-the-counter medication that has been brought in by the student in the manner indicated on the container.

I acknowledge that ST. PAUL SCHOOL does not have a school nurse. I agree to indemnify and hold harmless ST. PAUL 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. PAUL 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. PAUL 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:

_____ _____

Parent #1 - Print Name Parent #1 - Signature

_____ _____

Parent #2 - Print Name Parent #2 - Signature

_____

Date