



St. Thomas More Catholic School

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Medication Authorization Form

For this student to receive medication during school hours this form must be fully completed by the prescribing physician and an authorizing parent.

STUDENT: _____

GRADE: _____ BIRTHDATE: _____

Diagnosis requiring medication: _____

Medication Dosage: _____

Date of this order: _____ Discontinuation date: _____

Possible side effects: _____

Other medication the student is receiving:

Signature of Health Care Provider

Health Care Provided Phone Number

The above order must be fully completed. All medication is to be brought to school by a parent or responsible adult designee and must be in a PRESCRIPTION CONTAINER plainly marked with the student's name, medication name and dosage; including explicit directions for administration. Prescription directions must coincide with above order and be of current date. Neither the school nor school personnel incur liability for injury or illness or other damage resulting from administering medication prescribed by a licensed physician or other licensed medical personnel, and administered in accordance with the prescribed dosage.

*****Please Note: Unless other specified, only emergency medications will be sent on field trips and delivered under the supervision of the certified teach staff.***

PARENT AUTHORIZATION:

I hereby request that my son/daughter, _____, receive medication at school or on school related field trips as instructed by his/her physician. I give the school permission to be in contact with the prescribing physician with regards to the above medication order and the response my child has to the prescribed medication.

I assume responsibility for providing the school with medication that will not expire during the course of its intended use and stipulated above. I understand that the physician's order for medication must be renewed annually or whenever a medication or dosage is changed. I also understand that expired medication cannot be administered.

Parent's signature

Date