



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.

*****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