



**Marist**  
**School Medication Authorization Form**

This form is to be completed by the student's licensed prescriber and parent/guardian. All prescription and non-prescription medications must be properly labeled with the student's name, date of birth, and year of graduation. All prescription labels must contain the name of the medication, prescribed dosage, and time or times at which or the circumstances under which the medication is to be administered. These medications are kept in the Nurse's office. All unused or expired medication must be picked up from the Nurse's office by a parent/guardian before the end of the school year. Any medication remaining will be properly discarded. This form must be updated yearly.

Student Name: \_\_\_\_\_  
(Print)

Date of Birth: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

Medication Name: \_\_\_\_\_

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Time and Frequency of Administration: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Physician's Name Printed: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_



**PARENT/GUARDIAN AUTHORIZATION:**

I hereby acknowledge 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 Marist High School and its employees and agents to administer the above medication(s) during school hours. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than the school nurse, and specifically consent to such practices.

I agree and acknowledge that Marist High School and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the administration of medication(s) and I agree to waive any claims I might have, except for claims based on willful and wanton conduct, against Marist High School and/or its employees arising out of the administration of the medication listed above.

I acknowledge and agree that Marist High School and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the administration of asthma medication, epinephrine injector, or opioid antagonist, regardless of whether authorization was given by the student's parent/guardian, or by the student's physician, physician assistant, or advanced practice registered nurse. Furthermore, I acknowledge and agree to indemnify and hold harmless Marist High School and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration of asthma medication, epinephrine injector, or opioid antagonist to or by the above named student, regardless of whether authorization was provided by the student's parent/guardian or by the student's physician, physician assistant, or advanced practice registered nurse.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Cell: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_



**Marist**  
**Asthma and Allergy Medication Policy Statement**

Marist High School has received your request for self-administration and/or self-carry of:

\_\_\_\_\_ ,  
(List medication)

for your child, \_\_\_\_\_ .  
(Print student's name)

*Pursuant to Section 22-30(c) of the Illinois School Code, Marist High School and its employees and agents are to incur no liability or professional discipline, except for willful and wanton conduct, as a result of any injury arising from the administration of asthma medication or epinephrine injector to or by the above named student, regardless of whether authorization is given by the student's parent/guardian or by the student's physician, physician assistant, or advanced practice registered nurse. Before we can allow your child to self-administer the medication described above, you are required to sign and return this document.*

*The permission for self-administration of medication is effective for the school year for which it is granted and shall be renewed each subsequent school year upon fulfillment of the requirements outlined above. Additionally, if your student self-administers asthma medication at school, Marist High School will annually request you to submit an asthma action plan for your student. A student with asthma may possess and use his or her medication during school hours, at a school-sponsored activity (dance, game, etc.), on the school bus, and/or before or after normal school hours. We recommend that you provide an additional dose of the medication to be kept at school in the event that your child forgets or loses his or her medication.*

**Parent/Guardian Permission Statement**

I have read the above policy and acknowledge that Marist High School and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the administration of asthma medication or an epinephrine injector, regardless of whether authorization was given by the student's parent/guardian, or by the student's physician, physician assistant, or advanced practice registered nurse. Furthermore, I acknowledge and agree to indemnify and hold harmless Marist High School and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration of asthma medication or an epinephrine injector to or by the above named student, regardless of whether authorization was provided by the student's parent/guardian or by the student's physician, physician assistant, or advanced practice registered nurse.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Please contact our school nurse if you should have any questions:*

*Phone: 773-881-5352 - Email: gaida.amanda@marist.net - Fax: 773-881-1621*