Medication Authorization Policy School Year 2023-2024

Every student must have the two dark pink (cherry) forms on file.

Student's Name _____

Grade for 2023-2024 School Year _____

Please check all that apply:

_____ I read the School Medication Authorization Policy and Procedure

_____ My child is not on any medications home/school

_____ My child is on medication. The required permission and authorization forms from the prescribing physician and myself are enclosed.

_____ Asthma Action Plan

_____ Diabetes Care Plan

_____ Illinois Food Allergy Emergency Action Plan

_____

Parent/Guardian Signature

_____

Date

To be completed by parent/guardian for each child, submitted to the school annually, and updated immediately as needed.

MEDICAL AND EMERGENCY NOTIFICATION INFORMATION - AUTHORIZATION FOR MEDICAL TREATMENT

SCHOOL_____ SCHOOL YEAR_____

STUDENT NAME	DATE OF BIRTH	GRADE LEVEL	LIST MEDICAL ALLERGIES and/or SIGNIFICANT MEDICAL HISTORY

PLEASE PRINT

Parent/Guardian_____ Parent/Guardian_____

Home Phone ( )_____ Work( )_____ Home Phone ( )_____ Work ( )_____

Cell Phone ( )_____ Cell Phone ( )_____

Name of Student's Physician_____ Phone ( )_____

Address_____ City_____ State_____

Medical Insurance Provider_____ Policy/Insurance#_____

- Diabetes Care Plan Submitted (if applicable): YES/NO
- Asthma Action Plan Submitted (if applicable): YES/NO
- Illinois Food Allergy Emergency Action Plan and Treatment Authorization Form Submitted (if applicable): YES/NO

EMERGENCY CONTACTS IN CASE PARENT/GUARDIAN CANNOT BE REACHED:

NAME_____ RELATIONSHIP TO STUDENT _____

Phone 1 ( )_____ Phone 2 ( )_____

NAME_____ RELATIONSHIP TO STUDENT _____

Phone 1 ( )_____ Phone 2 ( )_____

MEDICAL RELEASE

In the event that the undersigned, or my/our authorized physician, cannot be reached and in the judgment of the School Principal or his/her designee, there is a necessity for immediate examination and/or treatment of my/our child, I/we hereby request and authorize school personnel to obtain for my/our child such medical services as are deemed necessary. I/We agree to assume the medical and liability insurance coverage and costs for any diagnosis/treatment and/or for medication deemed necessary. I/We understand that it may be necessary for my/our child's medical condition to be disclosed to school personnel and/or medical providers and I/we expressly consent to such disclosure.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

THIS FORM SHALL ACCOMPANY STUDENTS ON FIELD TRIPS. IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO UPDATE EMERGENCY INFORMATION AS NECESSARY.