To be completed by parent/guardian for each child and submitted to the school annually

MEDICAL AND EMERGENCY NOTIFICATION INFORMATION
AUTHORIZATION FOR MEDICAL TREATMENT

SCHOOL ____ SCHOOL YEAR _________________

STUDENT NAME	DATE OF BIRTH	GRADE	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 # _______________

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 authorized staff member, there is a necessity for immediate examination and/or treatment of my/our child, I/we hereby request and authorize any of the aforesaid personnel to obtain for my/our child such medical services as are deemed necessary. I/We agree to assume the financial responsibility for any diagnosis/treatment and/or for medication deemed necessary.

____ ______________________
PARENT/GUARDIAN SIGNATURE DATE

____ ______________________
PARENT/GUARDIAN SIGNATURE DATE

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

Archdiocese of Chicago
Office of Catholic Schools
June 2008

To be updated by parent/guardian/physician annually

MEDICATION AUTHORIZATION FORM

____ SCHOOL, _______________________, ILLINOIS

________________________________	_________________	_____	__________
Student Name (Last, First, Middle)	Date of Birth	Grade	Date

Medications may be administered in school in accordance with the School Medication Procedures. No medication may be administered in school unless both the student's physician and parent/guardian have completed, signed, and returned this entire form to the School and the Medication in the original labeled container as dispensed (prescription medication) or the manufacturer's labeled container (non-prescription medication). The medication label shall contain the student's name, name of the medication, direction for use and date.

Parent/Guardian Permission and 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 the School Principal or his/her designee, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer in accordance with School Medication Procedures), lawfully prescribed medication and non-prescribed medication in the manner described in the Physician's Order {Reverse side}. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual who does not have medical training, and I specifically consent to such practices.

I understand that this authorization is not effective unless the School Principal or his/her designee has approved the medication authorization for my child and signed this form in the space provided below.

I further acknowledge and agree that, when such medication is to be administered or attempted to be administered, I waive any claims I might have against the School, the Catholic Bishop of Chicago, the parish, or any of their employees or agents arising out of the administration or attempted administration. In addition, I agree to hold harmless and indemnify the School, the Catholic Bishop of Chicago, the parish, and their employees or agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempted administration of said medication.

______________________________ Parent/Guardian (PRINT)	______________________________ Parent/Guardian (PRINT)
______________________________ Parent/Guardian (SIGNATURE)	______________________________ Parent/Guardian (SIGNATURE)
______________________________ Address	______________________________ Address
______________________________ City, State, Zip Code	______________________________ City, State, Zip Code
______________________________ Home Phone Business Phone	______________________________ Home Phone Business Phone

To be updated by parent/guardian/physician annually

Physician's Order

Student ___________________________________ Grade ____________

______________________________ ____________ ____

Medication/ Health Care Treatment Dosage Time(s) to be administered

____ ____

Intended effect of this medication Expected side effects, if any

____

Other medications the student is taking

1) **May student self-administer medication under supervision of school personnel who do not have medical training?**

(Please circle) YES NO

2) **For ASTHMA and ALLERGY CONDITIONS ONLY**:
I certify that this student has been instructed in the use and self-administration of this medication and is capable of self-administering the medication independently and without supervision.

(Please circle) YES NO

I also request that this student be allowed to carry the above-described medication on their person during school hours and during school-related activities in order to facilitate the self-administration of the medication as needed.

(Please circle) YES NO

Administration Instructions:

____ _________________________________

Physician's /Prescriber's Signature Date Signed

____ _________________________________

Physician's/ Prescriber's Name (PRINT) Emergency telephone number

____

Address City , State, Zip Code

Medication Authorization approved or denied and signed this ____ day of _____________,
(Please circle one)

20 ___, by ____ on behalf of
Signature of Principal

_____________________________________School, _______________________ , Illinois

To be updated by parent/guardian/physician annually

MEDICATION AUTHORIZATION FORM

____ SCHOOL, _________________________, ILLINOIS

Student Name (Last, First, Middle)	Date of Birth	Grade	Date

Medications may be administered in school in accordance with the School Medication Procedures. No medication may be administered in school unless both the student's physician and parent/guardian have completed, signed, and returned this entire form to the School and the Medication in the original labeled container as dispensed (prescription medication) or the manufacturer's labeled container (non-prescription medication). The medication label shall contain the student's name, name of the medication, direction for use and date.

Parent/Guardian Permission and Authorization

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I further acknowledge and agree that, when such medication is to be administered or attempted to be administered, I waive any claims I might have against the School, the Catholic Bishop of Chicago, the parish, or any of their employees or agents arising out of the administration or attempted administration. In addition, I agree to hold harmless and indemnify the School, the Catholic Bishop of Chicago, the parish, and their employees or agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempted administration of said medication.

Parent/Guardian (PRINT)	Parent/Guardian (PRINT)
Parent/Guardian (SIGNATURE)	Parent/Guardian (SIGNATURE)
Address	Address
City, State, Zip Code	City, State, Zip Code
Home Phone Business Phone	Home Phone Business Phone

To be updated by parent/guardian/physician annually

Physician's Order

Student ___________________________________ Grade ____________

______________________________ ____________ ____
Medication/ Health Care Treatment Dosage Time(s) to be administered

____ ____
Intended effect of this medication Expected side effects, if any

____
Other medications the student is taking

1) **May student self-administer medication under supervision of school personnel who do not have medical training?**

(Please circle) YES NO

2) **For ASTHMA and ALLERGY CONDITIONS ONLY**:
I certify that this student has been instructed in the use and self-administration of this medication and is capable of self-administering the medication independently and without supervision.

(Please circle) YES NO

I also request that this student be allowed to carry the above-described medication on their person during school hours and during school-related activities in order to facilitate the self-administration of the medication as needed.

(Please circle) YES NO

Administration Instructions:

____ _________________________________
Physician's /Prescriber's Signature Date Signed

____ _________________________________
Physician's/ Prescriber's Name (PRINT) Emergency telephone number

____
Address City , State, Zip Code

Medication Authorization approved or denied and signed this ____ day of _____________,
(Please circle one)

20 ___, by ____ on behalf of
Signature of Principal

_____________________________________School, _______________________ , Illinois

PHOTO/ACADEMIC WORK PERMISSION FORM

On occasion, _________________________(school) uses photos and/or academic work of students in school/parish publications to share information about the school. School publications include, but are not limited to: the website, school yearbook, student academic work, advertisements, annual reports, posters, newsletters, parish bulletins and other public relations material.

In addition, local news organizations may hear of our activities or events, and our school may invite or allow them to photograph or record our events.

Please check and sign below:

_____ My child's photo or academic work may be published in any format including group or individual photos.

_____ My child's photo or academic work may **not** be published in any format including group or individual photos.

Printed Name of Student ______________________________________ Grade _____
Printed Name of Student ______________________________________ Grade _____
Printed Name of Student ______________________________________ Grade _____
Printed Name of Student ______________________________________ Grade _____

Printed Name of Parent/Guardian____

____Date ___________
Parent/Guardian Signature

If you do not return this form by ____________(date), it will be assumed that you give permission for your child's photo or academic work to be included in any form of communication.

PHOTO/ACADEMIC WORK PERMISSION FORM

On occasion, ________________________(school) uses photos and/or academic work of students in school/parish publications to share information about the school. School publications include, but are not limited to: the website, school yearbook, student academic work, advertisements, annual reports, posters, newsletters, parish bulletins and other public relations material.

In addition, local news organizations may hear of our activities or events, and our school may invite or allow them to photograph or record our events.

Please check and sign below:

_____ My child's photo or academic work may be published in any format including group or individual photos.

_____ My child's photo or academic work may **not** be published in any format including group or individual photos.

PLEASE PRINT:

Name of Student ____________________________________ Grade _____

Name of Student ____________________________________ Grade _____

Name of Student ____________________________________ Grade _____

Name of Student ____________________________________ Grade _____

Name of Parent/Guardian____

____ Date ___________

Parent/Guardian Signature

This form will remain in effect until the parent/guardian requests a change in writing.

If you do not return this form by ___________(date), it will be assumed that you give permission for your child's photo or academic work to be included in any form of communication.