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

Physician's Order

Student ___________________________________ Grade_________________

____ __________ __________________________
Medication/ Health Care Treatment Dosage Dosage Time(s) to be administrated

____ ____
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 (circle one) and signed this ____ day of ___________

20 ___, by ____ on behalf of
Signature of Principal

____________________________________School, ______________________ , Illinois

Archdiocese of Chicago
Office of Catholic Schools
June 2008