

Ss. Peter and Paul Catholic School
217 W 3rd Street, Waterloo, Il. 62298

Medical/Medication Information Consent Form
(As required by the State of Illinois)

Name of Student _____ Birthdate _____

Address _____ Telephone _____

School Attending _____ Grade/Teacher _____

FOR THE PHYSICIAN

Name of medication to be given _____

Disease/Illness medication to be given for _____

Dosage to be given _____

Time to be given _____

Possible length of time to be given _____

Possible side effects of the medication _____

**If medication is an inhaler, please indicate if it is medically necessary for the student to carry the inhaler with him/her at all times during school hours: _____

Physician's Signature _____ Date _____

Address _____ Telephone _____

FOR THE PARENT/GUARDIAN

I give consent for my child (Name) _____

To receive the above described medication(s) while at school.

My child is currently receiving the following medication(s) _____

Date medication(s) started) _____

This form must be completed each time there is a change in any medication. Medication must be brought to school in a container appropriately labeled by either the pharmacist or physician. Send only the dosage needed for one school day. NO MEDICATION WILL BE GIVEN UNTIL THIS COMPLETED FORM IS RECEIVED. Certified personnel will administer medication.

Additional forms will need to be completed if this medication is an inhaler, which needs to be self-administered during the school day

Parent/Guardian Signature _____ Date _____

**REQUEST FOR ADMINISTERING MEDICATION AT SCHOOL
AND RELEASE FROM LIABILITY FORM**

This must be presented to the school when a student returns to school with medication.

I/we, the undersigned parents/guardian of the minor child, _____,
a student at _____ School, hereby request said school to allow said child to
attend school in spite of his/her special health problem and to be given medication prescribed by
_____ from
to _____ under the supervision of school personnel.

The medicine is to be furnished by me and labeled by the physician or pharmacist with said child's
name, doctor and drug store, name of drug, and the specific time it is to be given at school. I/we
assume all responsibility for any mistake in furnishing an incorrect dosage.

For and in consideration of allowing said child to attend school in spite of his/her special problem,
we hereby release and discharge _____ School and/or any of its agents or
employees from any and all liability for any injury or damage to the health of said child arising out of
or resulting from the necessity of said child having to take medication during school hours. All
medication will be in its original container.

I/we have read, understand and agree to the school's regulations concerning giving medication at
school.

Signature _____ Date _____

Address _____

Home Telephone Number _____

Work Telephone Number _____