



MINOOKA COMMUNITY HIGH SCHOOL DISTRICT #111
Medical Authorization Form

Student: \_\_\_\_\_ Grade: 9 10 11 12
(last) (first)

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

Physician: \_\_\_\_\_

Emergency Hospital: [ ] Provena St. Joseph Medical Center [ ] Morris Hospital

If the parents and authorized physician(s) named above cannot be reached in the event of an emergency and if immediate observation or treatment is urgent in the judgment of the school authorities, do you authorize and direct the school authorities to send your child (properly accompanied) to the hospital or doctor? Yes \_\_\_\_ No \_\_\_\_

Other Instructions: \_\_\_\_\_

Allergies: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

I hereby give my permission to school authorities to give my son/daughter the following:
[ ] Acetaminophen (Tylenol) [ ] Benadryl (generic form)
[ ] Tums [ ] Ibuprofen (Advil)
[ ] My son/daughter will be carrying an inhaler at school.
[ ] My son/daughter will be taking prescription medication during the school day.
Date: \_\_\_\_\_ Signature: \_\_\_\_\_