

Immaculata Catholic School Parent/Guardian Medication Authorization & Provider Order Form

I **hereby** give permission to the school nurse or designee to administer the indicated medication(s) to my child as ordered by his/her licensed primary or specialty care provider.

I **understand** that:

- It is my responsibility to have an adult transport the medication and check it in with the nurse or designee at the school.
- All over the counter medication must be labelled with student name and dosage information.
- All prescription medication must be in the original container from the pharmacy indicating student name, medication name, dosage, frequency, method of administration, and date of expiration.

If the prescribed medication is not administered for any reason at the school, 911 will be called for emergencies and parents will be notified for non-emergencies.

If my child participates in ICS before/after-school activities/sports, I assume responsibility for notifying the instructor/coach of my child's condition. I will provide extra emergency medication for the activity.

I **hereby release** Immaculata Catholic School and staff from any and all liability for damages or injury that may result from my child being administered the ordered medication.

I **authorize** the release and exchange of limited medical information between my child's licensed care provider, school nurse and Immaculata that is necessary in carrying out services for my child.

Student Name: _____ Date of Birth: _____ Grade/Class: _____

Parent/Guardian Name: _____ Signature: _____ Phone: _____ Date: _____

	Diagnosis	Medication	Dosage (mg)	Route	Time	Comments
Daily	___ ADHD	_____	_____	_____ By Mouth	Timing: _____	
Allergy Medications	Allergy: Allergen:	Diphenhydramine (Benadryl) _____ Other _____	___ 12.5 mg ___ 25 mg ___ Other _____ mg	By Mouth: ___ Table ___ Liquid ___ Chewable	_____ Upon Exposure _____ Mild Reaction	Please Complete <u>Allergy</u> Action Plan:
	Emergency Allergy Medication:	Epinephrine Auto Injector	___ 0.15 mg ___ 0.3 mg	_____ Intramuscular	_____ Upon Exposure _____ Severe Reaction	Please Complete <u>Allergy</u> Action Plan:
Asthma	Green Zone:	___ Albuterol Other _____	___ 2 Puffs ___ Other _____	_____ Inhaler with Spacer _____ Nebulizer	_____ Before Exercise Other _____	Please Complete <u>Asthma</u> Action Plan:
	Yellow Zone:	___ Albuterol Other _____	___ 2 Puffs ___ 4 Puffs ___ 1 Vial ___ Other _____	_____ Inhaler with Spacer _____ Nebulizer	_____ Every 4 Hours Other _____	Please Complete <u>Asthma</u> Action Plan:
	Red Zone:	___ Albuterol Other _____	___ 4 Puffs ___ 1 Vial ___ Other _____	_____ Inhaler with Spacer _____ Nebulizer	_____ Severe Symptoms Other _____	Please Complete <u>Asthma</u> Action Plan:
Seizures	Type of Seizure:	___ Valtoco ___ Nayzilam Other _____	___ 5 mg ___ 10 mg ___ Other _____ mg	_____ Nasal Spray _____ Other	_____ Seizure Onset _____ After 5 Minutes After _____ Minutes	Please Complete <u>Seizure</u> Action Plan:
PRN Meds	Pain/Other	___ Tylenol/Advil Other _____	_____ mg _____ mg	_____ By Mouth _____ Other	Timing: _____	

Provider Name: _____ Signature: _____ Phone: _____ Date: _____ Stamp: _____