AS NEEDED MEDICATION ADMINISTRATION AUTHORIZATION

**This form must be renewed annually*

Student's Name _____DOB_____Grade_____

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, I hereby authorize the JCA school nurse, on my behalf, to administer or attempt to administer to my child or supervise self-administration by my child on an as needed basis the following:

Check all that apply:

____ibuprofen 200mg, 1-2 tablets by mouth every 4-6 hours as needed for temporary relief of minor aches and pain due to the common cold, arthritis, muscle aches, headache, toothache and fever. (max: 6 tablets per 24hr period). Generic for Mortin or Advil.

____Acetaminophen 500mg 1-2 tablets by mouth every 4-5 hours as needed for temporary relief of minor aches and pain due to the common cold, arthritis, muscle aches, headache, toothache and fever. (max: 8 tablets per 24hr period). Generic for Tylenol.

____Antacid Calcium Carbonate 1000mg 1-2 tablets chewed by moth every 2-3 hours as needed for relief of acid indigestion, sour stomach, heartburn and upset stomach. (max: 7 tablets per 24hr period). Generic for Tums.

____Loratadine 10mg 1 tablet by mouth every 24 hours as needed for temporary relief of sneezing, runny nose, itchy or watery eyes, itchy throat or nose. (max: 1 tablet per 24 hours). Generic for Claritin or Zyrtec.

____diphenhydramine 25mg, 1-2 tablets by mouth every 6 hours for temporary relief of hives, runny nose, sneezing, itchy or watery eyes, itchy throat/nose due to hay fever, allergies, cold symptoms. (max: 6 doses per 24 hr. period). Generic for Benadryl.

_____Hydrocortisone 1% topical cream. Dime sized amount applied to affected area 3-4 times daily for temporary relief of eczema, psoriasis, poison ivy, oak or sumac, insect bites, detergents, soaps or dermatitis. (max: 3-4 times daily). Generic for Cortisone 10

Parent/guardian authorization:

I certify that my child has been instructed in the use of the medication, understands the reason for the medication, and the necessity to report any usual side effects. My child is capable of using the medications independently. I agree to indemnify and hold harmless Joliet Catholic Academy, its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or self-administration of medications. It is my responsibility to notify the school nurse of any changes to my child's health status or medications. This authorization is effective for the duration of the school year which the form signed by the parent/guardian. This form must be renewed for each school year. I understand that I may revoke the authorization contained herein at any time in writing.

Parent/Guardian printed name and date: _____ _____/____/_____

Parent/Guardian signature_____

Parent/Guardian emergency phone number _____

Joliet Catholic Academy Health Office, 1200 North Larkin Avenue Joliet, IL 60435, 815-741-0500 Ext 275, 815-741-3015 fax, nurse@jca-online.org