Authorization for Administration of Medication
This form must be renewed annually

_____ _____ 9th 10th 11th 12th
Student's Name (Last, First, Middle) Date of Birth Grade Level (Circle one)

Physician Authorization

Condition(s) requiring medication at school_____

_____	_____	_____	_____
Medication	Dose/Route	Frequency/Time of Day	purpose / other requirements /circumstances
_____	_____	_____	_____
Medication	Dose/Route	Frequency/Time of Day	purpose / other requirements /circumstances
_____	_____	_____	_____
Medication	Dose/Route	Frequency/Time of Day	purpose / other requirements /circumstances
_____	_____	_____	_____
Medication	Dose/Route	Frequency/Time of Day	purpose / other requirements /circumstances

Other medications student is receiving_____

***For asthma rescue inhalers, epinephrine auto-injectors, and diabetic medications/supplies is unsupervised, self-administration authorized? Yes No (circle one)**

For Asthma rescue inhalers only please affix prescription label to this form

_____
Date

_____
Physician Signature

_____
Physician Name (Print or Stamp) / Phone #

_____
Physician Address

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Parent/Guardian Authorization

I hereby acknowledge that I am primarily responsible for administering medication to my child or ward. However, in the event that I am unable to do so, I hereby authorize the school nurse or her designee, on my behalf, to administer or attempt to administer to my child or supervise self-administration by my child the lawfully prescribed medication described above in the manner described above. I acknowledge that it may be necessary for the administration of medication to my child or ward to be performed by an individual other than the school nurse and specifically consent to such practices.

I authorized Joliet Catholic Academy and its employees and agents, to allow my child/ward to carry and self-administer his/her asthma inhaler, epinephrine auto-injector, or diabetic medications/supplies while in school, at a school sponsored activity, under the supervision of school personnel, and before or after normal school activities. 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, it 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 change in my child's health status or medication. **This authorization is effective for the duration of the school year during which the form is 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.**

_____
Date

_____ _____
Parent/Guardian Signature Emergency Phone # of Parent/Guardian

Joliet Catholic Academy, Health Office, 1200 N. Larkin Avenue Joliet, IL 60403, 815-741-0500 Ext 275, 815-741-3015 fax, nurse@jca-online.org

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