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

Student Name: _____ Date of Birth: _____ School Year: _____

To be completed by parent/guardian

I understand that:

- Non-medical personnel (e.g., trained school staff) conduct the medication administration.
- 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 in original packaging, labelled with student name and dosage information.
- All prescription medication must be in the original pharmacy container indicating student name, medication name, dosage, frequency, method of administration, and date of expiration.
- If a prescribed emergency medication is not administered for any reason at the school, 911 will be called for emergencies.
- If my child has a change in their condition, medication, and/or dosing instructions, including dose, I must notify the school and submit an updated Medication Authorization and Provider Order form as soon as possible.

I request that:

- My child be administered the medication as indicated in the providers' order.
- If an emergency administration is ordered, I give permission for the school nurse to instruct designated personnel in the administration technique.

I authorize:

The release and exchange of medical information between my child's provider, school nurse, and Immaculata/ the Diocese of Raleigh that is necessary in carrying out services for my child.

I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed healthcare provider.

I hereby release the Diocese of Raleigh and their agents and employees from any and all liability or injury that may result from my child taking the prescribed medication.

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

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.

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	Diagnosis	Medication Name Right Medication	Dosage Right Amount	How to give Right Route	When to give Right Time
☐Daily ☐PRN	_____ _____				
Allergy	List of Allergens:	☐ Diphenhydramine (Benadryl) ☐ Other _____	☐ Dose:	☐ By Mouth ☐ Other _____	☐ Upon Exposure ☐ Mild Reaction
		☐ Epinephrine Auto Injector	☐ 0.15 mg ☐ 0.3 mg	☐ Intramuscular (IM) injection	☐ Upon Exposure ☐ Severe Reaction
		☐ Epinephrine nasal spray	☐ 1 mg ☐ 2mg	☐ Intranasal (in the nostril)	☐ *If provided*: repeat dose after __ minutes if symptoms continue (if intranasal, in SAME nostril as first administration)
Asthma	Green Zone Exercise Induced	☐ Albuterol ☐ Other _____	☐ 2 Puffs ☐ Other _____	☐ Inhaler with Spacer ☐ Nebulizer	☐ DAILY before exercise ☐ AS NEEDED before exercise ☐ Other_____
	Yellow Zone	☐ Albuterol ☐ Other _____	☐ 2 Puffs ☐ 4 Puffs ☐ 1 Ampule/Vial ☐ Other _____	☐ Inhaler with Spacer ☐ Nebulizer	☐ Every 4 hours as needed ☐ Other_____
	Red Zone	☐ Albuterol ☐ Other_____	☐ 4 Puffs ☐ 1 Vial ☐ Other _____	☐ Inhaler with Spacer ☐ Nebulizer	For EMERGENCY symptoms
	Other asthma medications (ex: Symbicort, Dulera, etc.)	☐ _____ ☐ _____ ☐ _____ ☐ with spacer	Please complete with specific numbers of puffs and minutes – - no ranges ☐ Green/exercise: ____ puffs inhaled before exercise as needed to prevent symptoms ☐ Yellow Zone: ___ puff(s) inhaled every ____ minutes for cough/wheeze/shortness of breath, up to ___ puff(s). Call parent if symptoms have not improved after ___ puffs. ☐ Red Zone: CALL 911. ___puff(s) inhaled every ___ minutes up to ___ puffs		
Seizures	Type of Seizure:	☐ Diastat ☐ Valtoco ☐ Nayzilam ☐ Other_____	☐ Dose	☐ Rectal Gel ☐ Nasal Spray ☐ Other _____	☐ At seizure onset ☐ After 5 minutes ☐ After ____minutes ☐ Other _____
Diabetes	Insulin Delivery: ☐ Pump ☐ Pen ☐ Syringe Frequency of blood glucose checks: ☐ When student feels unwell ☐ Prior to meals/snacks ☐ Prior to physical activity ☐ Other _____ ☐ Ketone check when glucose < ____ Notify parents if ketones < _____	☐ Glucagon ☐ GVoke ☐ Baqsimi ☐ Other _____	☐ Dose	☐ Subcutaneous (SQ) ☐ Intramuscular (IM) ☐ Nasal Spray ☐ Other: _____	HYPOglycemia (LOW): <_____ (TREAT IMMEDIATELY) • Conscious/cooperative: use LOW treatment/fast acting carb _____ o Recheck glucose after _____ minutes. o If < _____ repeat fast-acting carb • Unconscious: stay with student, place student on side, call 911, call parents HYPERglycemia (HIGH): > _____ • Student well: recheck in 2 hours, encourage water) • Student unwell (ex, vomiting): check ketones, call parents • For both: if glucose still above _____ in 2 hrs, call parents

PARENT/GUARDIAN MUST SIGN "To be completed by parent" SECTION ON THE BACK OF THIS FORM.

Provider's Printed Name: _____ Provider Phone: _____ Date: _____ Provider Stamp: _____

Provider's Signature: _____ Provider fax/secure email: _____ Nurse Review/Signature/Date: _____