



All Saints Catholic Academy MEDICATION ORDER

ONE FORM PER ORDER BY HEALTH CARE PROVIDER

School Year: 2016-2017

Student's Name: _____ Date of Birth: _____ Male () Female ()

Medication _____ Prescription () Over-the-Counter ()

Diagnosis: _____ Dosage: _____ Frequency: _____

Contraindications/Side effects/Adverse reactions: _____

NOTE: MEDICATION MUST BE IN ORIGINAL CONTAINER AND LABELED APPROPRIATELY

Health Provider Information: Name _____

Address _____ Phone #: _____

City/State/Zip Code: _____

Signature of Health Care Provider: _____ Date: _____

Parent/Guardian Consent: Name: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____

I give permission to allow the Health Attendant or designee to give the following medication to my child:

*** I GIVE PERMISSION FOR MY CHILD TO SELF-ADMINISTER THIS MEDICATION: Yes () No ()

If reply is YES, please complete pages 2 and 3, Self-Administration of Medication and Allergy / Medical Action Plan(s) as it applies to your Student.

Signature of Parent/Guardian: _____

Relationship to Student; _____ Date signed: _____

IMPORTANT: ALL INFORMATION NEEDS TO BE COMPLETED FOR FORM TO BE VALID



**Authorization for the Self-Administration of Medication
For
STUDENT WITH ASTHMA**

To: All Saints Catholic Academy, 1155 Aurora Avenue, Naperville, Illinois 60540

The undersigned, _____ (hereinafter "Parent/Guardian") is the Parent/Guardian of _____ (hereinafter "Student") who is in the _____ Grade Class at All Saints Catholic Academy (hereinafter "School").

Parent/Guardian of Student hereby authorizes and directs the School to allow my Student to self-administer asthma medication pursuant to the written statement of my Student's Medical Provider. (i.e., ASCA Medication Order form or comparable Physician form.)

Parent/Guardian acknowledges that this Authorization is being provided pursuant to the Illinois School Code (105 ILCS 5/22-30). In addition, Parent/Guardian acknowledges that Student has the ability to properly self-administer such medication as prescribed by his/her Medical Provider.

INDEMNIFICATION AND HOLD HARMLESS AGREEMENT

By signing below, the Parent/Guardian hereby agrees to indemnify, defend and hold harmless the School, Parish and Roman Catholic Diocese of Joliet Trust, its administrators, servants, employees, agents, successors and assigns (collectively "School Affiliates"), both in their capacities as representatives of the School, the Parish and/or Diocese of Joliet and as individuals, from and against any loss, actions, responsibilities, obligations, liability, damages, expenses, or claims with regard to the self-administration of medication by my student, _____, or any other liabilities which may be incurred by or asserted against any of the School Affiliates, directly or indirectly resulting from the self-administration of medication by my student, _____, with the exception of willful and wanton conduct on the part of any School Affiliates.

Parent/Guardian Signature: _____ Date: _____



ALLERGY/MEDICAL ACTION PLAN

Student: _____ Grade: _____

Allergy/Medical Condition: _____

Asthmatic: * Yes () No () * **High risk for severe reaction**

Briefly describe your Student's usual Symptoms:

Indicate action(s) to be taken when symptoms occur:

Minor reaction: _____

Major reaction: _____

Then call: 911 (For major reaction)

1. **PARENT/GUARDIAN:** _____ **PHONE:** _____

2. **MEDICAL PROVIDER:** _____ **PHONE:** _____

Parent/Guardian Signature: _____ Date: _____

POSSIBLE SYMPTOMS TO EXPECT, THOUGH NOT ALL INCLUSIVE

| | |
|---------------|---|
| MOUTH | itching and swelling of lips, tongue or mouth |
| THROAT | itching and/or a sense of tightness in throat; hoarseness and hacking cough |
| SKIN | hives, itchy rash and/or swelling about the face or extremities |
| GUT | nausea, abdominal cramps, vomiting and/or diarrhea |
| LUNG | shortness of breath, repetitive coughing and/or wheezing |
| HEART | "thready" pulse, "passing out" |