All Saints Catholic Academy
MEDICATION ORDER

ONE FORM PER ORDER BY HEALTH CARE PROVIDER School Year: 2019-2020

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 Heath 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"

Authorization for the Self-Administration of Medication For

_____

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 _____ 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:_____