2023- 2024 Immaculata Catholic School Parent/Guardian Medication Authorization & Provider Order Form

I hereby give permission to the school nurse or designee to administer the indicated medication(s) to my child as ordered by his/her licensed primary or specialty care provider.

I understand that:

- 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 labelled with student name and dosage information.
- All prescription medication must be in the original container from the pharmacy indicating student name, medication name, dosage, frequency, method of administration, and date of expiration.

If the prescribed medication is not administered for any reason at the school, 911 will be called for emergencies and parents will be notified for non-emergencies.

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.

I hereby release Immaculata Catholic School and staff from any and all liability for damages or injury that may result from my child being administered the ordered medication.

I authorize the release and exchange of limited medical information between my child's licensed care provider, school nurse and Immaculata that is necessary in carrying out services for my child.

Student Name: ________________________________Date of Birth: ______________Grade/Class for 2023-2024: ______________

Parent/Guardian Name: ______________________________Signature:_____________________________________Phone: ____________________ Date:____________________

	Diagnosis	Medication	Dosage (mg)	Route	Time	Comments
Daily	___ ADHD	______________________	____________________	______ By Mouth	Timing: __________	
Allergy Medications	Allergy: Allergen:	Diphenhydramine (Benadryl) ______________________ Other _______________	___ 12.5 mg ___ 25 mg ___ Other _______ mg	By Mouth: ___ Table ___ Liquid ___ Chewable	_________ Upon Exposure _________ Mild Reaction	Please Complete Allergy Action Plan:
	Emergency Allergy Medication:	Epinephrine Auto Injector	___ 0.15 mg ___ 0.3 mg	______ Intramuscular	_________ Upon Exposure _________ Severe Reaction	Please Complete Allergy Action Plan:
Asthma	Green Zone:	____ Albuterol Other________________	___ 2 Puffs ___ Other _______	______ Inhaler with Spacer ______ Nebulizer	_________ Before Exercise Other__________________	Please Complete Asthma Action Plan:
	Yellow Zone:	____ Albuterol Other ______________	___ 2 Puffs ___ 4 Puffs ___ 1 Vial ___Other _______	______ Inhaler with Spacer ______ Nebulizer	_________ Every 4 Hours Other________________	Please Complete Asthma Action Plan:
	Red Zone:	____ Albuterol Other________________	___ 4 Puffs ___ 1 Vial ___ Other _______	______ Inhaler with Spacer ______ Nebulizer	_______ Severe Symptoms Other__________________	Please Complete Asthma Action Plan:
Seizures	Type of Seizure:	___ Valtoco ___ Nayzilam Other________________	___ 5 mg ___ 10 mg ___ Other _______ mg	______ Nasal Spray ______Other	_________ Seizure Onset _________ After 5 Minutes After ____Minutes	Please Complete Seizure Action Plan:
PRN Meds	Pain	_____ Tylenol _____ Advil (Ibuprofen)	_________mg _________mg	______ By Mouth	Timing: __________	

Provider Name: ______________________ Signature:________________________________ Phone:________________________Date:__________________Stamp:__________________