

**AUTHORIZATION AND PERMISSION FOR ADMINISTRATION OF MEDICATION**  
**JORDAN CATHOLIC SCHOOL AND JORDAN DAYCARE**  
**Office of the School Nurse ..... Phone: (309) 793-7350 x200 ..... Fax: (309) 793-7361**

In accordance with the Illinois Department of Human Services and Illinois State Board of Education Recommended Guidelines for Medication Administration in Schools:

- Written orders shall be received from the physician for both prescription and non-prescription medications (includes Benadryl Cream, Caladryl Lotion, Carmex, cough drops, and throat lozenges.
- Written permission shall be received from the parent / guardian.
- Medication shall be delivered to school in a pharmacist labeled container or manufacturer's labeled container.
- Notification shall be received when the drug is discontinued.
- Medication guidelines shall be renewed annually.
- Medication should be scheduled to be given between 9:00 A.M. and 1:00 P.M. if at all possible.
- While in school, students, may not have any medications with themselves nor in their book bag or lunch boxes.

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

**PHYSICIAN AUTHORIZATION:**

Medication / Health Care Treatment \_\_\_\_\_

Dosage and administration directions \_\_\_\_\_

Reason (Disease / condition) \_\_\_\_\_

Possible side effects \_\_\_\_\_

Other medications student is taking \_\_\_\_\_

May student self-administer medication under supervision of Health Service personnel or designate? (Please Circle) YES NO

Discontinue / Re-evaluate / Follow-up (Circle One) Date \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

Prescriber's Phone Number \_\_\_\_\_ Address \_\_\_\_\_

**PARENTAL AUTHORIZATION:**

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Jordan Catholic School and its employees and agents, on my behalf and stead, to administer or attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of Jordan Catholic School), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the school its employees and agents arising out of the administration of said medication. In addition I agree to hold harmless and indemnify the school, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Parent/Guardian Signature \_\_\_\_\_

Home Phone \_\_\_\_\_

Business Phone \_\_\_\_\_