ST. JOSEPH SCHOOL
MEDICATION AUTHORIZATION FORM

Please Note: A separate form must be completed for EACH medication that is to be administered during school hours by St. Joseph School personnel.

Student's Name:_____ Date of Birth:_____

Address:_____ Telephone:_____

Diagnosis:_____ Name of Medication:_____

Dosage:_____ Route (Circle One): Oral Inhaled Injected Other (specify)_____

Frequency during school hours:_____ Specific Time (if any):_____

Observed Side Effects in this patient:_____

Possible Side Effects:_____

Other Medications Prescribed for this student:_____

Possible Drug Interactions:_____

Physician's Name (Please Print):_____

Address:_____ Telephone:_____

Physician's Signature:_____ Date:_____

St. Joseph School and its employees and agents, are hereby authorized to administer to the above named student or to allow the self administration of the lawfully prescribed medication described above. I further acknowledge and agree that when the lawfully prescribed medication is so administered I waive any claims against St. Joseph and its employees which might arise out of the administration of said medication. In addition, I agree to indemnify and hold harmless St. Joseph School, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense therof, incurred or resulting from the administration of said medication.

_____ _____

Signature of Parent or Legal Guardian **Date**

PLEASE SEE REVERSE SIDE FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION

SELF-ADMINISTRATION OF ASTHMA MEDICATION
(PHYSICIAN, PHYSICIAN ASSISTANT OR ADVANCED PRACTICE RN)

Pursuant to the School Code, St. Joseph School will permit the self-administration of medication by a student with asthma, if the following documents are provided by the student's parents or guardians:

1. Written authorization, signed by the parent or guardian; and
2. A written statement from the student's physician, physician assistant or advanced practice registered nurse, containing the following information:
   a. The name and purpose of the medication
   b. The prescribed dosage; and
   c. The time or times at which or the special circumstances under which the medication is to be administered

St. Joseph School and its employees and agents will incur no liability, except for willful and wanton conduct, as a result of any injury arising for the student's self-administration of the medication.

The following student is presently under my care for asthma. Information relating to the student's self-administration of the asthma medication referenced herein, which I have prescribed, is set forth below.

Student's Name:_____ Date of Birth:_____
Name of Medication:_____ Dosage of Medication:_____
Purpose of Medication:_____
Time or times at which, or special circumstances under which, the medication is to be administered:_____

I have instructed the student in proper inhaler technique and find that the student is able to administer inhaler independently.

Signature of Physician/Provider	Date	Name of Physician/Provider
Street Address	City, State, Zip Code	
Office Phone Number	Emergency Phone Number	

Parent signature giving permission for self-administration of medication for my child:

Parent Signature	Date