# JOSEPH ACADEMY

1101 Gregory Street, Des Plaines, IL 60016 (847)803-1930 Fax (847)803-8669
1100 North 22nd Avenue, Melrose Park, IL 60160 (708)345-4500 Fax (708)345-4516
9003 South Kostner Avenue, Hometown, IL 60456 (708)952-1100 Fax (708)952-0287
420 County Farm Road, Wheaton, IL 60187 (630)407-2541 Fax (630)407-2545
Michael Schack, Executive Director

## School Administration Form #1

*To be filled out by Parent/Guardian*

Student Name ____________________________

Birth Date _________________

I am the Mother/Father/Legal Guardian (please circle one) of the child named above. I give my permission to the Joseph Academy school personnel to supervise the administration of medication as requested by my doctor.

_______________________________________________________________
Name of Doctor

I will bring the medication to the school nurse in the container supplied by the pharmacy. *No medications will be accepted in any other container.*

_________________ _______________________________________________
Date Signature of Parent/Guardian

_______________________________________________________________
Address

_______________________________________________________________
City State Zip

_______________________ _____________________________ ___________________________
Home Phone Business Phone Emergency Phone

*Please send this form to the school nurse. No medications will be administered without form(s) being returned.*

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**School Administration Form #2**

*To be filled out by physician*

Student Name ____________________________________________ Date ______________________

The above student has _______________________________________________________________

(name of disease or syndrome)

I request that s/he be given the following medication at school: ________YES ________NO

Name of Medication: _________________________________________________________________

Dosage and time to be given: ________________________________________________________

Tablet, liquid, or capsule: __________________________________________________________

Desired effects: ____________________________________________________________________

Side effects: _______________________________________________________________________

Does this student have any known allergies? ___________________________________________

Please describe: ____________________________________________________________________

Is this student on any other medication? If so, please give medication name, dosage and frequency:_______________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_________________ ______________________________________________________________

Date Signature of Doctor

_______________________________________________________________

Address of Doctor

_______________________________________________________________

City State Zip

______________________________ ________________________________

Emergency Phones

*Please send a written medication order along with this form to the attention of the school nurse.*