Morton Unit School District 709
School Medication Authorization and Release Form

A new form must be completed every school year for prescription and non-prescription medications to be administered at school.

To be completed by the student's parent/guardian:

Student's name_____ Student's birthdate_____
Address_____
School_____ Grade _____ Teacher_____
Parent/Guardian name _____ Cell phone_____
Parent's home phone_____ Work phone _____
Student's medication allergies_____

PART I - PHYSICIAN'S STATEMENT This statement must be completed by the student's physician, physician's assistant or advanced practice registered nurse having such authority delegated by a supervising/collaborating physician. NOTE: A physician's statement is not required for students who require asthma inhalers during the school day. For asthma inhalers, please refer to Part II on the next page.

Prescriber's printed name_____
Office address_____
Office phone_____ Office fax_____

Medication name _____ Dosage_____
Time to be given in school _____
Route of administration_____
Any other special circumstances under which medication is to be administered:
_____
Diagnosis requiring medication_____
Intended effect_____
Expected side effects, if any _____
Date of prescription _____ Discontinuation date _____
Other medication the student is receiving _____
Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition? Yes or No
Has this medicine been previously administered to the student? Yes or No
Is supervised self-administration authorized? Yes or No

For Asthma Medication/Epinephrine Auto-Injectors Only*:
*NOTE: Pursuant to Illinois law, upon parental consent (for asthma inhalers) or physician authorization (for epinephrine auto injector), a student who is prescribed asthma medication and/or epinephrine auto-injector may possess and use his/her asthma medication and/or epinephrine auto-injector while at school or during school-sponsored activities without the supervision of District personnel. For epinephrine auto-injector only:
Is the student able to carry and self-administer this medication? Yes or No

I hereby request that the school nurse or authorized school personnel administer the above prescribed medication as it is medically necessary to do so while at school or during school-sponsored activities.

Prescriber's Signature_____ Date _____

PART II - PRESCRIPTION FOR ASTHMA INHALERS (To be completed by parent/guardian)

For asthma inhalers only, please attach a photocopy of the prescription label containing the name of the medication, dosage and time at which, or special circumstances that the medication is to be administered.

PART III – AUTHORIZATION, WAIVER AND INDEMNIFICATION (To be completed by parent/guardian)

I hereby consent to and authorize Morton Unit School District 709 to

(Check the option that applies):

____ Administer medication to my student while at school or during school-sponsored activities according to the above instructions. I hereby confirm my primary responsibility to administer medication to my student. However, in the event that I am unable to do so, I hereby authorize Morton Unit School District 709 and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my student lawfully prescribed medication in the manner described above. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATION TO MY STUDENT TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE AND SPECIFICALLY CONSENT TO SUCH ADMINISTRATION. I waive any claims against the School District, members of the Board of Education, its employees, and agents arising out of the administration of said medication, and agree to release, hold harmless, and indemnify the School District, the members of the Board of Education, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorneys' fees, resulting from or arising out of the administration of medication or storage of any medication by school personnel.

____ Permit my student's possession and unsupervised self-administration of asthma medication or use of epinephrine auto injector while at school or during school-sponsored activities according to the above instructions. I waive any claims against the School District, members of the Board of Education, its employees, and agents arising out of the self-administration of said asthma medication or use of said epinephrine auto-injector, and agree to hold harmless and indemnify the School District, the members of the Board of Education, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorneys' fees, resulting from or arising out of the self-administration of asthma medication or use of epinephrine auto-injector. I also acknowledge that the School District, members of the Board of Education, its employees, and agents shall incur no liability, except for willful and wanton conduct, as a result of any injury arising from my student's self-administration of asthma medication or use of epinephrine auto-injector, regardless of whether the self-administration of an asthma inhaler or epinephrine auto-injector was authorized by the parent or healthcare provider. I attest that I have provided the District with a copy of my student's prescription label (for asthma inhalers) or my student's physician's authorization (for epinephrine autoinjectors). This School Medication Authorization and Release Form and attached documentation shall be valid only for the school year in which they are submitted. A new form and supporting documentation must be submitted to the District each subsequent school year.

For Asthma Medication/Epinephrine Auto-Injectors Only: I consent to my child's possession and unsupervised self-administration of asthma medication/epinephrine auto-injector: **Yes or No**.

* I authorize Morton Unit School District 709 to contact my child's physician to receive medication authorization.

Parent/Guardian printed name:_____

Parent/Guardian signature: _____

Date: _____

*Foster parents must obtain a legal guardian (DCFS) signature.

Completed form reviewed by District 709 nursing staff:

Signature _____ Date: _____

*THE SCHOOL DISTRICT RETAINS THE DISCRETION TO REJECT REQUESTS FOR ADMINISTRATION OF MEDICINE.[1]

[1] July 2021