Form 615

PEORIA PUBLIC SCHOOL DISTRICT NO. 150

School Medication Authorization and Release Form

THE SCHOOL DISTRICT RETAINS THE DISCRETION TO REJECT REQUESTS FOR ADMINISTRATION OF MEDICINE

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

Student's Name_____ Student's Birthdate_____

Address _____ Zip _____ Home Phone _____

Parent/Guardian _____ Cell Phone _____ Work Phone _____

School _____ Grade_____ Teacher _____

PART I - PHYSICIAN'S STATEMENT

This statement must be signed by the student's physician, physician's assistant or advance 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 below*:

Name of Medication _____ Dosage _____

Time to be given in school _____ Date of prescription _____ Discontinuation date _____

Route of administration and/or other special circumstances under which medication is to be administered _____

_____

Diagnosis requiring medication _____

Intended effect_____

Expected side effects, if any _____

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_____No

Has this medicine been previously administered to the student _____Yes _____No Date of first usage _____

If this is the first time this student has taken this medicine, is it necessary that a registered nurse administer first dose at school? _____Yes_____No **(If** Yes, administered by_____R.N. Date _____)

Is supervised self-administration authorized? _____

For Asthma Medication/Epinephrine Auto-Injectors Only*: Is unsupervised self-administration authorized? _____

***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.*

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. For epinephrine auto-injector only:
Is the student able to carry and self-administer this medication? Yes____ No_____

Physician's name – signature _____ Date _____

Physician's name - print _____ Office Phone _____

Address _____ Emergency Phone_____

OVER

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PART II - PRESCRIPTION FOR ASTHMA INHALERS

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

PART III – AUTHORIZATION, WAIVER AND INDEMNIFICATION

I hereby consent to and authorize Peoria Public School District No. 150 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 Peoria Public School District No. 150 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 auto-injectors).

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 _____ No.

PART IV – CONSENT FOR EMERGENCY TREATMENT

I, _____, parent [or legal guardian] of _____, have enrolled my child in Peoria Public School District No. 150 and hereby authorize Dr. _____, my child's physician, or any physician in his or her group practice, on my behalf to administer emergency medical assistance to my child during school or a school-sponsored activity. In the event my child's physician or any physician in his or her group practice is not available, or contact with my child's physician is not practical under the circumstances, I hereby authorize Peoria Public School District No. 150, its employees and agents to provide emergency medical assistance or to arrange for and consent to on my behalf immediate medical treatment by a licensed or certified physician or other medical personnel for my child whenever the authorized school personnel believe such emergency medical assistance is necessary to protect the health, safety and welfare of my child. I further waive any claims against Peoria Public School District No. 150, the members of the Board of Education, its employees and agents arising out of the provision of or arrangement for emergency medical assistance to my child and agree to hold harmless and indemnify Peoria Public School District No. 150, the members of its 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 provision of or arrangement for emergency medical treatment.

*Parent/Guardian printed name:_____

*Parent/Guardian signature: _____ Date: _____

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

Form checked by District 150 nurse: Signature _____ Date: _____

Original: Temporary File in Cumulative Folder/Copy: Appropriate School Personnel 239214_2.DOCX

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