J. Sterling Morton High Schools
Morton East High School - 708.780.4000 extension 2213
Morton West High School - 708.780.4100 extension 3613
Morton Freshman Center - 708.863.7900 extension 1211

PHYSICIAN'S AUTHORIZATION FOR IN-SCHOOL MEDICATION ADMINISTRATION OR HEALTH CARE TREATMENT

Student's Name _____ Birth date _____ School ID# _____

MEDICATION OR HEALTH CARE TREATMENT

Dosage _____ Time/ Frequency to be administered _____

Intended effect of this medication or treatment _____ Possible Side effects (if any) _____

Additional Administration Instructions or Comments

_____

_____

_____

May student self-administer medication under the supervision of Health Care personnel or designate?
(Please circle) YES / NO

Special storage requirements needed: Refrigeration_____ Other_____ None needed_____

Prescriber's Name Printed _____ Prescriber's Signature _____

Date _____ Prescriber's Phone Number _____ Prescriber's 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 J. S. Morton High School District 201 and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of District 201), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than the 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 District 201, its employees and agents arising out of the administration of said medication. In addition I agree to hold harmless and indemnify the School District, 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 and administration or attempts at administration of said medication.

Parent's Signature _____ Date _____

Home Phone Number _____ Cellular Phone (or other daytime phone number) _____

My child may carry and self-administer his or her asthma inhaler(s) and/or Epi-pen as ordered per the physician _____ YES _____ NO