

**LISLE COMMUNITY UNIT SCHOOL DISTRICT 202  
MEDICATION AUTHORIZATION FORM**

STUDENT NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_ TEACHER (if applicable): \_\_\_\_\_

EMERGENCY PHONE NUMBER: \_\_\_\_\_ HOME PHONE NUMBER: \_\_\_\_\_

I hereby confirm 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 Lisle C.U.S.D. 202 and its employees and agents, in 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 the School District), lawfully prescribed medication in the manner described below. ***I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATIONS TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A 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 the School District, 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 the administration or attempts at administration of said medication.

**For parent(s)/guardian(s) of students who have asthma or allergies:**

I authorize the School District and its employees and agents, to allow my child or ward to possess and use his or her asthma medication and/or an EpiPen® or Twinject™ auto-injector (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school care on school-operated property. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self administration of medication (105 ILCS 5/22-30). I agree to indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the pupil.

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**\*\*\*INFORMATION BELOW TO BE COMPLETED BY PHYSICIAN OR DENTIST\*\*\***

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NAME AND STRENGTH OF MEDICATION: \_\_\_\_\_ DOSAGE: \_\_\_\_\_

ROUTE OF ADMINISTRATION: \_\_\_\_\_ TIME(S) TO BE ADMINISTERED AT SCHOOL: \_\_\_\_\_

**For inhaler and auto-injector orders only:**

Student has been taught proper usage of medication and may carry and self-administer (Circle one)    **yes**    **no**  
*If student needs both medications, please fill out two medication forms*

DATE OF PRESCRIPTION: \_\_\_\_\_ DISCONTINUATION DATE: \_\_\_\_\_

DIAGNOSIS REQUIRING MEDICATION: \_\_\_\_\_

INTENDED EFFECT OF THIS MEDICATION: \_\_\_\_\_

IS THIS MEDICATION NECESSARY IN ORDER TO MAINTAIN THE CHILD AT SCHOOL? \_\_\_\_\_

SIDE EFFECTS, if any: \_\_\_\_\_

OTHER MEDICATION STUDENT IS RECEIVING: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: (office) \_\_\_\_\_ (emergency) \_\_\_\_\_ (fax) \_\_\_\_\_