Medical Authorization Form

TO: PARENTS AND GUARDIANS

RE: MEDICATION ADMINISTERED AT SCHOOL

If it is essential for your child to receive medication during the school day, on a field trip, or on an extended field trip, it will be necessary for you to comply with the following District 202 policy:

1. The Medication Authorization Form **must be completed AND SIGNED BY BOTH the parent and physician**. (see the reverse side of this letter)

DISTRICT PERSONNEL CANNOT AND WILL NOT GIVE ANY MEDICATION WITHOUT A SIGNED MEDICATION FORM

2. The medication must be brought to school **by a parent or guardian in a pharmaceutical container** clearly marked with:
   - **a. Student name**
   - **b. Name of medication**
   - **c. Dosage instructions**
3. These forms must be renewed **YEARLY** (or sooner if needed) **AND** when there is **a change of dosage or frequency**.

THIS POLICY ALSO INCLUDES ALL OVER THE COUNTER MEDICATIONS SUCH AS TYLENOL, IBUPROFEN, ANTACIDS AND ASPIRIN.

The required Medication Authorization Form is found on the reverse side of this letter. Once completed, it should be returned to the Health Office along with the medication. Please feed free to contact your school nurse ifyou have any questions. Thank you.

Sincerely,

Carol Schmidtke, RN | Grades EC-3
Patti DeNichols, RN | Grades 4-8
Darlene Musbach, RN | Grades 9-12

Fax numbers for District 202 buildings

Lisle Elementary School 630.963.8843
Lisle Junior High 630.493.8209
Lisle High School 630.971.1234

LISLE COMMUNITY UNIT SCHOOL DISTRICT 202
MEDICATION AUTHORIZATION FORM

STUDENT ____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

NAME AND STRENGTH OF MEDICATION ____ DOSAGE __________________________

ROUTE OF ADMINISTRATION ________________________ TIME(S) TO BE ADMINISTERED AT SCHOOL ________________________

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) ____________________

FOR INHALER AND AUTO-INJECTOR ORDERS ONLY:

Student has been taught proper usage of medication and may carry and self-administer (check one) ☐ Yes ☐ No

If student needs both medications, please fill out two medication forms.