OUTDOOR EDUCATION

PARK RIDGE-NILES
SCHOOL DISTRICT 64

MEDICATION AUTHORIZATION FORM

Student Name ______________________________ Birth date ___________

Allergies ________________________________ Ht/Wt ____________

REQUIRED FOR ALL MEDICATION

To be completed and signed by Healthcare Provider (MD/DO/APN/PA)

Include Prescription Medication, Vitamins, Supplements, and Over-the-Counter Medication not listed below.

MEDICATION	DOSE	FREQUENCY	SIDE EFFECTS

Please ***check*** *the box* to mark which may be given from RN stock supply. ***Include dosage*** .

- ☐ **Acetaminophen:** **Dose** ______________
- ☐ **Ibuprofen:** **Dose**______________
- ☐ **Benadryl:** **Dose**______________
- ☐ **Chloraseptic Throat Spray**
- ☐ **Cough Drops**
- ☐ **Tums**
- ☐ **Calamine Lotion**
- ☐ **Orajel**

HEALTHCARE PROVIDER SIGNATURE **PHONE#** **DATE**

My signature below indicates my agreement for trained school district staff, under the supervision of the school nurse, to administer/monitor the self-administration of the above listed medications, according to the instructions provided, during the Outdoor Education trip. I agree to indemnify and hold harmless School District 64 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration, or the child's self-administration of medication.

PARENT/GUARDIAN SIGNATURE **PHONE#** **DATE**

rev. 1/16