



PARK RIDGE-NILES SCHOOL DISTRICT 64

OUTDOOR EDUCATION 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.

<u>MEDICATION</u>	<u>DOSE</u>	<u>FREQUENCY</u>	<u>SIDE EFFECTS</u>

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

- | | |
|--|--|
| <input type="checkbox"/> Acetaminophen: Dose _____ | <input type="checkbox"/> Cough Drops |
| <input type="checkbox"/> Ibuprofen: Dose _____ | <input type="checkbox"/> Tums |
| <input type="checkbox"/> Benadryl: Dose _____ | <input type="checkbox"/> Calamine Lotion |
| <input type="checkbox"/> Chloraseptic Throat Spray | <input type="checkbox"/> 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