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.

MEDICATION	DOSE	FREQUENCY	SIDE EFFECTS

Please ***check*** *the box* to mark which may be given from RN stock supply. ***Include dosage*** .
If dosage is not provided, medication dose will be given according to student's weight and package instructions.

☐ **Acetaminophen:** **Dose** __________________ ☐ **Cough Drops**

☐ **Ibuprofen:** **Dose**__________________ ☐ **Tums**

☐ **Benadryl:** **Dose**__________________ ☐ **Calamine Lotion**

☐ **Chloraseptic Throat Spray** ☐ **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**