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.

MEDICATION	DOSE	FREQUENCY	SIDE EFFECTS

_____ _____ _____

☞ 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**