OUTDOOR EDUCATION MEDICATION PERMISSION
NAPERVILLE SCHOOL DISTRICT 203

STUDENT'S NAME: ______________________________________ PHONE: _______________________

ADDRESS: _________________________________ GRADE: ____ SCHOOL: ______________________

I hereby request that Naperville School District 203/Aurora University Lake Geneva Campus/Lorado Taft Employees administer or supervise the administration of medication to my child in accordance with the routine described under the Guidelines for the Administration of Medication in Naperville School District 203.

I hereby release Naperville Community Unit School District 203/Aurora University Lake Geneva Campus/Lorado Taft employees, administrators or other parties from any liability for any injury or harm which is suffered by ____________ __________________________ as a result of the agreement to honor this request. I agree to indemnify and hold harmless the Naperville School District/Aurora University Lake Geneva Campus/Lorado Taft from any legal action or other attempts to acquire compensation, including damages and legal and medical fees, whenever these entities have acted in accordance with the information provided by my child's physician.

____
PARENT/GUARDIAN SIGNATURE DATE

Name of Medication ________________________________

Dosage ________ Times Taken ________________

Reason for Medication ______________________________

Name of Medication ________________________________

Dosage ________ Times Taken ________________

Reason for Medication ______________________________

Name of Medication ________________________________

Dosage ________ Times Taken ________________

Reason for Medication ______________________________

Name of Medication ________________________________

Dosage ________ Times Taken ________________

Reason for Medication ______________________________

Name of Medication ________________________________

Dosage ________ Times Taken ________________

Reason for Medication ______________________________

For Staff Use Only				
M	T	W	Th	F

____
PHYSICIAN'S SIGNATURE/LICENSED PRESCRIBER'S NAME DATE PHONE

PHYSICIANS: <u>PLEASE VOID OUT UNUSED SPACES</u>

10/03 40-9