GENEVA COMMUNITY UNIT SCHOOL DISTRICT #304
MEDICATION AUTHORIZATION FORM FOR 5th GRADE OUTOOR EDUCATION

Student Name: ____**Teacher**________________________
Birthdate: ____
Any known drug allergies: ____
Primary Parent contact—Name: __________________________ Phone: ______________________________

The following is a list of all medications my child will need to have administered during their Outdoor Education Trip. Please include any prescription and non-prescription medications alike. **This form requires both physician and parent signatures. Medications must be in their original labeled containers. Please bring all medications to the school health office at least one week prior to the Outdoor Education Trip.**
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Circle time to be given
prn=as needed

Medication:

#1____________________________________ Dose ________________ breakfast lunch dinner bed prn
Diagnosis requiring medication: ________________________________
Intended effect/expected side effects: ______________________________

#2 ____________________________________ Dose __________________ breakfast lunch dinner bed prn
Diagnosis requiring medication: __________________________________
Intended effect / expected side effects: ______________________________

#3 ____________________________________ Dose__________________ breakfast lunch dinner bed prn
Diagnosis requiring medication: __________________________________
Intended effect / expected side effects: ____________________________

#4 ____________________________________ Dose__________________ breakfast lunch dinner bed prn
Diagnosis requiring medication: __________________________________
Intended effects / expected side effects: ____________________________

#5 ____________________________________ Dose__________________ breakfast lunch dinner bed prn
Diagnosis requiring medication: __________________________________
Intended effects / expected side effects: ____________________________

____ / ____
Physician Name (print) **Physician Signature**

Physician phone**:** ________________________________ Fax: _____________________________________

____/ Date: ____
Parent Signature: *(Parent signature also required on reverse side)

Camp RN use only/RN initial time of administration

	Day 1:			Day 2:				Day 3:	
	Lunch	Dinner	Bedtime	Breakfast	Lunch	Dinner	Bedtime	Breakfast	lunch
Med1									
Med2									
Med3									
Med4									
Med5									

Signature and initials of camp nurse: ____

Student Name: ____Birthdate: ____________

Medication Waiver

I hereby confirm primary responsibility to administer medication to my child. However in the event that I am unable to do so, I hereby authorize GENEVA PUBLIC SCHOOLS and its employees and agents, in my behalf, to administer, or attempt to administer, to my child, or allow my child to self administer, while under the supervision of the employees and agents of the School District, lawfully prescribed medication in the manner described above. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATIONS TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN THE SCHOOL NURSE OR HEALTH AIDE, AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I further acknowledge and agree that, when the lawful prescribed medication is so administered, or attempted to be administered, I waive any claims I might have against the School District, or injuries incurred or resulting from the administration, or attempt at administration of said medication. I hereby grant the School District permission to contact the physician prescribing the medication for my child when deemed necessary.

____ / _______________________

(Parent Signature) **(Date)**

Nurse's Notes: *(camp RN use only)*