Supervisor Review

Initials:_______________
Date:_________________

Request and Waiver to Administer a Prescription Medication

Medication cannot be administered without a Physician's written order.

Please fill out this form if you indicated that your child has a condition that may require medication during your Park District Program. Return this form to the Arlington Heights Park District, 410 N. Arlington Heights Road, Arlington Heights, IL 60004 or FAX to 847.385.9425, five business days prior to the start of program.

Name of Participant: _____________________________________ Date of Birth:____________________
Address:____ City/Zip:________________________
Name of Parent/Legal Guardian: _____________________________ Phone Number: ______________
Program: ___________________________________ Location: _________________________________

PHYSICIAN'S STATEMENT

Condition requiring medication: ____

Medication Name: ____

Dosage: __________________________________ Route of administration:_________________________

Frequency and times to be given:____

Duration (week, month, etc.):____

Reaction to medication/Side effects:____
____

Any special storage requirements: ____
____

Other medications participant is receiving:____
____

Name of Physician: ____Phone Number: ________________
Physician's Signature:______________________________________ Date Signed:____________________

WAIVER

I _____________________________, myself/or the parent/guardian of ____________________________ give permission to the staff of the Arlington Heights Park District to administer the above prescription medication to my child.

I understand that it is my responsibility to give the prescription medication directly to the Arlington Heights Park District staff in the original container, showing the prescribing physician's name and telephone number, with complete dosage requirements.

I agree to waive and relinquish all claims and do hereby fully and forever release and discharge the Arlington Heights Park District and its officers, agents, servants and employees from any and all claims I may have as a result of administering a prescription medication for my child that I have specified in this request.

Signature: ____ Date: ___________________________