



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: _____