

**GENEVA PARK DISTRICT
REQUEST FOR THE ADMINISTRATION OF MEDICINE**

***MEDICATIONS CANNOT BE ADMINISTERED AT THE PARK DISTRICT WITHOUT A DOCTOR'S
WRITTEN ORDER AND A WRITTEN REQUEST FROM THE PARENT OR GUARDIAN.***

Name of Participant _____ Date of Birth _____
Address City/Zip _____
Day Phone _____ Work Phone _____ Cell Phone # _____
Program _____ Grade _____

Part I - Physician's Statement

1. Name/type of medication _____
2. Dosage/amount to be given _____
3. Route of administration _____
4. Frequency and time of administration _____
5. Duration (week, month, indefinite, etc.) _____
6. Diagnosis, intended effect, and anticipated reaction to medication _____

(Symptoms, side effects, etc.) _____

7. Other medication child is receiving _____

8. Other requirements _____

9. Must this medication be administered during the Park District program in order to allow the participant to attend the program? ☐ Yes ☐ No

Physician's Signature

Date Signed

Address

Telephone No.

Part II - Parent's Request/Approval

I hereby request and grant permission for Park District staff to dispense medication to my child, _____, according to the above instructions. I further waive any claims against the Park District, members of the Board of Commissioners, its employees, and agents arising out of the administration of said medication and agree to hold harmless and indemnify the Park District, the members of the Board of Commissioners, its employees and agents, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorney fees, resulting from or arising out of the administration of medication.

Parent / Guardian Signature _____ Phone # _____ Date _____