Medication Dispensing Information

This form must be completed for each program session or when medication changes.

BACKGROUND INFORMATION:

Participant's Name:_____ Age:_____

Address:_____

Parent's/Guardian's Name(s)_____

Daytime Phone:_____ Other Phone:_____

Program Name:_____

Doctor's Name:_____ Phone:_____

MEDICATION INFORMATION:

1. Name:_____ Dose:_____ Time:_____

   Dispensing & Storage Instructions:_____

   _____

   Possible Side Effects:_____

   _____

2. Name:_____ Dose:_____ Time:_____

   Dispensing & Storage Instructions:_____

   _____

   Possible Side Effects:_____

   _____

3. Name:_____ Dose:_____ Time:_____

   Dispensing & Storage Instructions:_____

   _____

   Possible Side Effects:_____

   _____

OTHER INFORMATION:_____

_____

_____

_____

I understand that it is my responsibility to give the medication directly to program staff with full instructions in individual dosage containers, clearly labeled envelopes, or in original prescription bottles.

In all cases, medication dispensing can only be changed or modified by completing another Permission and Waiver to Dispense Medication Form and Medication Information Form.

I hereby acknowledge that the above information provided for the dispensing of medication for my minor child, guardian, ward, or other family member is accurate. I also understand that it is my responsibility to inform the agency if any changes in the dispensing of medication change.

_____ _____

Signature of Parent or Guardian **Date**

DeKalb Park District

Permission to Dispense Medication

Waiver and Release of All Claims

The DeKalb Park District will not dispense medication to a minor child or other DeKalb Park District participant until the Permission and Waiver to Dispense Medication and Medication Information Form have been fully completed by a parent or guardian. The agency's internal procedures on dispensing medication are available for review.

NAME OF PROGRAM:_____DATE:_____

I _____ the parent/guardian of _____
(Print Name) (Print Name)
give permission to the staff of the DeKalb Park District
to administer to my child _____.
(Name of Medication(s))

I understand it is my responsibility to give the medication directly to the program staff in individual dosage containers, original prescription containers, or envelopes clearly labeled with the following information:

PARTICIPANT'S NAME:_____

NAME OF MEDICINE AND COMPLETE DOSAGE INSTRUCTIONS:

_____

_____

In all cases, the recommended dosage of any medication will not be exceeded. If after administering medication there is an adverse reaction, I give my permission to the DeKalb Park District to secure from any licensed hospital physician and/or medical personnel any treatment deemed necessary for immediate care. I agree to be responsible for payment of any and all medical services rendered.

WAIVER & RELEASE OF ALL CLAIMS

I recognize and acknowledge that there are certain risks of physical injury in connection with the administering of medication to my minor child. Such risks include, but are not limited to, failing to properly administer the medication, failing to observe side effects, failing to assess and/or recognize an adverse reaction, failing to assess and/or recognize a medical emergency, and failing to recognize the need to summon emergency medical services.

In consideration of the DeKalb Park District administering medication to my minor child, I do hereby fully release or discharge the DeKalb Park District, and its officer, agents, volunteers and employees from any and all claims from injuries, damages and losses I or my minor child may have (or accrue to me or my minor child), and arising out of, connected with, incidental to, or in any way associated with the administering of medication.

_____ _____

Signature of Parent or Guardian **Date**