**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:

Quantity supplied: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dispensing & Storage Instructions:

Possible Side Effects:

2. Name: Dose: Time:

Quantity supplied: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dispensing & Storage Instructions:

Possible Side Effects:

3. Name: Dose: Time:

Quantity supplied: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dispensing & Storage Instructions:

Possible Side Effects:

**OTHER INFORMATION:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MAY CHILD/PATRON SELF-ADMINISTER MEDICATION?**

CIRCLE: YES NO (If yes, *Self-Administration* form must be completed)

I understand that it is my responsibility to give the medication directly to program staff with full instructions in unopened individual dosage containers, unopened non-prescription medication containers, or in original prescription bottles. I further understand that, in the case of a program field trip, it is my responsibility to provide a satisfactory storage container. *i.e.*, a portable cooler for insulin.

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 Park District if any changes in the dispensing of medication change.

**Signature of Parent or Guardian Date**