Medication Dispensing Information Form

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 deliver all medication to the agency office in the original prescription bottle contained in a separate, clearly marked container which includes the person's name, medication, dosage, and time of day medication is to be given, along with any other necessary instructions**.**

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 and I hereby authorize the dispensing of medication to my minor child, guardian, ward, or other family member whose name is _____. 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**

Permission To Dispense Medication Form
Waiver and Release of All Claims

The Lemont Park District will not dispense medication to a minor child or other 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 Lemont Park District **to administer to my child :**
_____.
(Name of Medication)

I understand that it is my responsibility to deliver all medication to the agency office in the original prescription bottle contained in a separate, clearly marked container which includes the person's name, medication, dosage, and time of day medication is to be given, along with any other necessary instructions.

Parent/Guardian must complete 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 Lemont Park District to secure from any licensed hospital physician and/or medical personnel (including, but not limited to emergency 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 Lemont Park District, administering medication to my minor child, I do hereby fully release or discharge the Lemont 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**