Centre of Elgin Youth Program
Permission to Dispense Prescription Medication

The City of Elgin will not dispense medication to a student unless this form has been completed by a parent or legal guardian. Medication will not be administered until this form is complete.

Prescription Medicine

In order for us to dispense Prescription medicine it must be in a labeled original prescription container with the child's name, address, physician name, and pharmacy phone number listed on container. The container must also list the reason for dosage and instructions.

Child's Name: _____Program: _____

I, _____, the parent and/or legal guardian of _____ give permission to the City of Elgin staff to administer to my child the following medication _____ from this date _____ to this date _____.

List symptoms that would indicate need for this medication:_____
_____

Complete dosage instructions: Dose: _____ Time: _____
_____
_____

Possible Side Effects: _____

Storage Instruction: _____

Non-Prescription Medicine

The City of Elgin will not dispense Non-Prescription medicine or over the counter medicine to a child.

I understand that it is my responsibility to give the medication directly to the program staff in clearly marked prescription containers that list the child's full name, address, dosage amount, physician name and pharmacy name and phone number. In all cases the recommended dosage of any medication will not be exceeded. If after administering medication there is an adverse reaction, I give permission to the City of Elgin to secure any deemed necessary emergency medical services.

I understand, in all cases, medication dispensing can only be changed or modified by completing Permission to Dispense Medication Form.

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

Signature of Parent or Guardian: _____ Date: _____