2527.1 MEDICATION DISPENSING INFORMATION

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

Program Name: _____ Session: _____

BACKGROUND INFORMATION

Participant's Name: _____ Age: _____

Address: _____

Parent/Guardian's Name(s): _____

Daytime Phone: _____ Other Phone: _____

Doctor's Name: _____ Doctor's Phone: _____

MEDICATION INFORMATION

1. Name of Medication: _____ Dose: _____ Time: _____

   Dispensing & Storage Instructions: _____

   _____

   Possible Side Effects: _____

   _____

2. Name of Medication: _____ Dose: _____ Time: _____

   Dispensing & Storage Instructions: _____

   _____

   Possible Side Effects: _____

   _____

3. Name of Medication: _____ Dose: _____ Time: _____

   Dispensing & Storage Instructions: _____

   _____

   Possible Side Effects: _____

   _____

(OVER)

4. Name of Medication: _____ Dose: _____ Time: _____

Dispensing & Storage Instructions: _____

_____

Possible Side Effects: _____

_____

OTHER INFORMATION

_____

_____

_____

PARENT/GUARDIAN'S STATEMENT

I understand that it is my responsibility to give to program staff any medications in individual dosage containers, in clearly labeled envelopes, or in original prescription bottles for my minor child, guardian, ward, or other family member with full instructions as to dosage requirements and possible side effects.

I understand that in all cases, medication dispensing can only be changed or modified by completing another "*Permission to Dispense Medication (Waiver and Release)*" form (#2527.2) and the "*Medication Dispensing Information*" form (#2527.1). I further understand that it is my responsibility to inform the Bartlett Park District if anything should change relating to the dispensing of medication for my minor child, guardian, ward, or other family member.

I understand that 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 Bartlett Park District to secure from any licensed paramedic, 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.

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.

_____ _____ _____

Signature of Parent/Guardian Printed Name Date

Date Approved by Executive Director: 06/2013

Director's Signature: *Rita Fletcher*

Revised/Reviewed Date: 10/08/01, 6/23/04, 08/2008, 11/2010, 08/15/12, 05/22/13