Medication Dispensing Information

THIS FORM ONLY NEEDS TO BE COMPLETED IF MEDICATION WILL BE GIVEN AT THE PROGRAM. IT MUST BE COMPLETED FOR EACH PROGRAM SESSION AND/OR WHEN MEDICATION CHANGES.

Participant's Name:	Age:			
Parent/Guardian Name(s):				
Medication Information: (fill in for each medicine)				
Name of Medicine:	Dosage:			
Medication form: Tablet Capsule Liquid Injection Other_				
Dispensing & Storage Instructions:	······			
Possible Side Effects:				
Dates to be administered: From To				
Time to be administered: am pm pm	Time to be administered: am pm			
Name of Medicine:	Dosage:			
Medication form: Tablet Capsule Liquid Injection Other_				
Dispensing & Storage Instructions:				
Possible Side Effects:				
Dates to be administered: From To				
Time to be administered: am pm pm	Time to be administered: am pm			
What are some signs to be aware of?				
ASTHMA, ALLERGY, or DIABETIC MEDICATION ONLY - (E.g. Inhalers, Epi-Pen, Ir 1. May carry medication on his/her person Yes * No 2. May self-administer medication Yes * No * If you answered Yes to the above questions, please also complete & sign th				
I understand it is my responsibility to give the medication directly to the program staff with full instructions in individual dosage containers, clearly labeled envelopes, or in original prescription containers. In all cases, medication dispensing can only be changed or modified by completing another Permission to Dispense Medication Waiver and Medication Dispensing 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 Byron Park District if any changes in the instructions for dispensing of medication occur.				
Parent/Guardian Signature:	Date:			



Permission to Dispense Medication Waiver & Release

The Byron 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/guardian.

Name of program: Date:			
		parent/guardian of (print name) ct to administer to my child (list me	
individual dosage containers,	clearly labeled envelor pharmacist for a dup	cation directly to the program staff pes, or in original prescription conta licate prescription bottle, if needed	ainers with the following
is an adverse reaction, I give	my permission to the E y treatment deemed n	ation will not be exceeded. If after a Byron Park District to secure from ar ecessary for immediate care. I agree	ny licensed hospital physician
medication to my minor child failing to observe side effects	l. Such risks include, bu , failing to assess and/	risks of physical injury in connection at are not limited to, failing to prope or recognize an adverse reaction, fa anize the need to summon emergen	erly administer the medication, iling to assess and/or
discharge the Byron Park Dist	rict, and its officers, ag I or my minor child ma	ering medication to my minor child, gents, volunteers and employees fro y have, arising out of, connected wi	om any and all claims and
employees from any and all o	laims resulting from in	end the Byron Park District, its offic njuries, damages and losses sustaine ny way associated with the administ	d by me or my minor child and
Parent/Guardian Signature: Date:			-
Parent/Guardian Phone:		Alternate Phone:	
Medication Date RECEIVED	Staff Signature	Medication Date RETURNED	Parent Signature