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 **Time to be administered:** ____ am ____ 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 **Time to be administered:** ____ am ____ 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, Insulin, etc.)

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 the ***Inhaler/Auto Injector Waiver Form***

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:** _____

PLEASE COMPLETE THE REVERSE SIDE OF THIS DOCUMENT

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: _____

I, (print name) _____ the parent/guardian of (print name) _____ give permission to the staff of the Byron Park District to administer to my child (list medications) _____

_____

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 with the following information (You can ask your pharmacist for a duplicate prescription bottle, if needed):

- **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 Byron Park District to secure from any licensed 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 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 Byron Park District administering medication to my minor child, I do hereby fully release or discharge the Byron Park District, and its officers, agents, volunteers and employees from any and all claims and injuries, damages and losses I or my minor child may have, arising out of, connected with, incidental to, or in any way associated with the administering of medication.

I further agree to indemnify, hold harmless and defend the Byron Park District, its officers, agents, volunteers and employees from any and all claims resulting from injuries, damages and losses sustained by me or my minor child and arising out of, connected with, incidental to or in any way associated with the administering or failure to administer medication.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Phone: _____ Alternate Phone: _____

Medication Date RECEIVED	Staff Signature	Medication Date RETURNED	Parent Signature