Permission to Dispense Medication

Waiver and Release of All Claims

The Dundee Township Park District will not dispense medication to a minor child or other participant until the Permission 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 by request.

Participant's First Name: ______________________________ Last Name: ______________________________

I, ______________________________ the parent/guardian of ______________________________
(Print Name) (Print Name)

give permission to the staff of the Dundee Township Park District to administer the following medication to my child

____ .
(Name of Medication(s))

- ❑ I understand it is my responsibility to give the medication directly to the program staff in individual dosage containers, original prescription containers, or envelopes clearly labeled with the participant's full name, name of medicine and complete dosage instructions.
- ❑ In all cases the recommend dosage of any medication will not be exceeded. If after administering medication there is an adverse reaction, I give my permission to the Dundee Township 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 have completed the Medication Dispensing Information form. I understand that the Medication Dispensing Information form must be completed for each program session or when medication changes.
- ❑ I understand 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 information provided for the dispensing of medication for my minor child, guardian, ward, or other family member is accurate. I understand that it is my responsibility to inform the Dundee Township Park District if any changes in the dispensing of medication changes.

Waiver and 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 and/or recognize an adverse reaction, failing to recognize the need to summon emergency medical services.

In consideration of the Dundee Township Park District administering medication to my minor child, I do hereby fully release or discharge the Dundee Township 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: ______________

Medication Dispensing Information

Program Name: ______________________________

Participant's Name: ______________________________ Age: __________

Address: ______________________________

Parent's/Guardian's Name: ______________________ Phone #______________

Parent's/Guardian's Name: ______________________ Phone #______________

Doctor's Name: ______________________ Phone #______________

Medication Name	Given	Storage Instructions	Time of Day
______________	❑ Daily ❑ As Needed	**Needs Refrigeration?** ❑ Yes ❑ No **Other** ______________	______ ______ ______
Possible Side Effect		**Dosage/How to Give?**	
______________ ______________		______________ ______________	

Medication Name	Given	Storage Instructions	Time of Day
______________	❑ Daily ❑ As Needed	**Needs Refrigeration?** ❑ Yes ❑ No **Other** ______________	______ ______ ______
Possible Side Effect		**Dosage/How to Give?**	
______________ ______________		______________ ______________	

Medication Name	Given	Storage Instructions	Time of Day
______________	❑ Daily ❑ As Needed	**Needs Refrigeration?** ❑ Yes ❑ No **Other** ______________	______ ______ ______
Possible Side Effect		**Dosage/How to Give?**	
______________ ______________		______________ ______________	

Parent Guardian's Signature: ______________________ Date: ______________

Medication Log

Signature: ______________________

Participant's Name: ______________________ Age: __________ Program: ______________________ Session: ______________________

Medication: ______________________ Dosage: ______________________ Month: ______________________ Year: ______________________

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials
17	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**	
Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	**Only One Medication Per Chart**

Medication Log

Signature: ______________________

Participant's Name: ______________________ Age: __________ Program: ______________________ Session: ______________________

Medication: ______________________ Dosage: ______________________ Month: ______________________ Year: ______________________

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials
17	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**	
Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	Time(s) Initials	**Only One Medication Per Chart**