



## Dispensing of Medication Information Form

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

### BACKGROUND INFORMATION:

Participant's Name: \_\_\_\_\_

Age: \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_

Parent's/Guardian's Name(s) \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Program Name \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Phone: \_\_\_\_\_

### MEDICATION INFORMATION:

1. Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Time: \_\_\_\_\_

Dispensing & Storage Instructions: \_\_\_\_\_

\_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

\_\_\_\_\_

2. Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Time: \_\_\_\_\_

Dispensing & Storage Instructions: \_\_\_\_\_

\_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

\_\_\_\_\_

(Over)

# Medication Dispensing Information Form

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3. Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Time: \_\_\_\_\_

Dispensing & Storage Instructions: \_\_\_\_\_

\_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

\_\_\_\_\_

OTHER INFORMATION: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I understand that it is my responsibility to give the medication directly to Oak Lawn Park District Staff with full instructions in individual dosage containers, clearly labeled envelopes, or in original prescription bottles.**

**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 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 Oak Lawn Park District if any changes in the dispensing of medication change.**

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date



## Permission To Dispense Medication Waiver and Release of All Claims

The Oak Lawn Park District will not dispense medication to a minor or other participant until the Permission and Waiver 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.

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**NAME OF PROGRAM:** \_\_\_\_\_

I \_\_\_\_\_ the parent/guardian of \_\_\_\_\_  
*(Print Name)* *(Print Name)*  
give permission to the staff of the Oak Lawn Park District to administer to my child the  
following medication(s) \_\_\_\_\_.

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**I understand it is my responsibility to give the medication directly to the Oak Lawn Park District Staff in individual dosage containers, original prescription containers, or envelopes clearly labeled with the following information:**

**PARTICIPANT'S NAME:** \_\_\_\_\_

**NAME OF MEDICINE AND COMPLETE DOSAGE INSTRUCTIONS:**

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**-OVER-**

**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 Oak Lawn 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. In consideration of the Oak Lawn Park District administering medication to my minor child, I do hereby fully release or discharge the Oak Lawn 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, 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 Oak Lawn Park District and 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 of medication.**

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**Signature of Parent or Guardian**

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**Date**

