

### Medication Dispensing Information

This form must be completed for each program session or when medication changes. Please fill out and return if applicable. If your child does not need any medication during camp hours than this form is not required.

#### BACKGROUND INFORMATION:

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

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

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

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

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

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

#### MEDICATION INFORMATION:

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Time: \_\_\_\_\_

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

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

#### MEDICATION INFORMATION:

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Time: \_\_\_\_\_

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

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

I understand that it is my responsibility to give the medication directly to program 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 agency if any changes in the dispensing of medication change.

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

\_\_\_\_\_  
Date

(Revised April 2011)



**Woodridge Park District**  
**Permission to Dispense Medication**  
***Waiver and Release of All Claims***

The Woodridge 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 or guardian. The agency's internal procedures on dispensing medication are available for review.

NAME OF PROGRAM: \_\_\_\_\_ DATE: \_\_\_\_\_

I \_\_\_\_\_ the parent/guardian of \_\_\_\_\_

give permission to the staff of the Woodridge Park District to administer \_\_\_\_\_  
to my child. (Name of Medication)

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 following information:

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 Woodridge Park District to the 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.

**WAIVER & 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, 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 Woodridge Park District administering medication to my minor child, I do hereby fully release or discharge the Woodridge 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