



Buffalo Grove  
Park District

# MEDICATION DISPENSING INFORMATION FORM

(This form must be completed for each program session or when medication changes)

**PARTICIPANT INFORMATION:**

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

**1. 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 \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM

**2. 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 \_\_\_\_\_ AM/PM \_\_\_\_\_ AM/PM

**MISCELLANEOUS INFORMATION (what are some signs to be aware of):** \_\_\_\_\_

**ASTHMA, ALLERGY, OR DIABETIC MEDICATION ONLY - (i.e. Inhalers, Epi-Pen, Insulin, etc.)**

1. May carry medication on his/her person ( ) Yes ( ) No

2. May self-administer medication ( ) Yes ( ) No

Directions for self-administration \_\_\_\_\_

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 Buffalo Grove Park District if any changes in the instructions for dispensing of medication occur.

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

\_\_\_\_\_  
Date

**PLEASE COMPLETE THE REVERSE SIDE OF THIS DOCUMENT**



Buffalo Grove  
Park District

# PERMISSION TO DISPENSE MEDICATION WAIVER AND RELEASE OF ALL CLAIMS

The Buffalo Grove 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, (print name) \_\_\_\_\_ the parent/guardian of (print name) \_\_\_\_\_  
give permission to the staff of the Buffalo Grove 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 Buffalo Grove 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 Buffalo Grove Park District administering medication to my minor child, I do hereby fully release or discharge the Buffalo Grove Park District, and its officers, 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 Buffalo Grove 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.

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

\_\_\_\_\_  
Date

(\_\_\_\_\_) \_\_\_\_\_  
Parent or Guardian Home Phone

(\_\_\_\_\_) \_\_\_\_\_  
Parent or Guardian Alternate Phone (Work or Cell)

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

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