Permission to Dispense Medication
Waiver and Release of All Claims

The Clarendon Hills Park District will not dispense prescription or over-the-counter 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.

Reference:
Participant Name: _____

Program Participating In: _____

I,_____, the parent/guardian of
(Print Parent/Guardian Name)

_____ give permission to the Clarendon Hills Park District staff
(Print Participants Name)

to administer the following: _____
(Print name of medication)

I understand it is my responsibility to give the medication directly to the program staff in individual dosage containers or original prescription containers clearly labeled with the following information.

Participants 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 Clarendon Hills 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 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 Clarendon Hills Park District administering medication to my minor child, I do hereby fully release or discharge the Clarendon Hills Park District, and its officer, agents, volunteers and employees from any and all claims from injuries, damages and losses I or my 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:

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

BACKGROUND INFORMATION:

Camper Information			
Last Name:	First Name:	Age:	
Address:	City:	State:	Zip:
Program Name:			

Parent/Guardian Information #1	**Parent/Guardian Information #2**
☐ Ms. ☐ Mr.	☐ Ms. ☐ Mr.
First & Last Name:	First & Last Name:
Home Phone: Work Phone:	Home Phone: Work Phone:

Doctor's Information
First & Last Name:
Work Phone:

MEDICATION INFORMATION:

1. Medication:_____ Dose:_____ Time:_____

Dispensing & Storage Instructions:

_____

_____

Possible Side Effects:

_____

_____

2. Medication:_____ Dose:_____ Time:_____

Dispensing & Storage Instructions:

_____

_____

Possible Side Effects:

_____

_____

3. Medication:_____ Dose:_____ Time:_____

Dispensing & Storage Instructions:

_____

_____

Possible Side Effects:

_____

_____

OTHER INFORMATION:

_____

_____

_____

I understand it is my responsibility to give the medication directly to the program staff with full instructions in individual dosage containers or original prescription containers clearly labeled.

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**