

Permission to Dispense Medication

Waiver and Release of all claims

The Crete 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.

Name of Program _____ Date _____

I, _____ the parent/guardian of _____
Print Name Print Name

Give permission to the staff of the Crete Park District to administer to my child

Name of Medication.

I understand that 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:

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 Crete Park District Staff 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 connections with the administering of medications to my minor child. In the consideration of the Crete Park District Staff administering medication to my minor child, I do hereby fully release or discharge the Crete 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 the administering of medication. I further agree to indemnify, hold harmless and defend the Crete 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.

Signature of Parent of Guardian

Date

Medication Dispensing Information

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

Background Information:

Participant Name: _____ Age; _____

Address _____

Parent/Guardian Name(s) _____

Phone _____ Emergency Phone _____

Program Name _____

Doctor's Name _____ Phone _____

Medication Information

1. Name; _____ Dose _____ Time _____

Dispensing and Storage Instructions: _____

Possible side effects: _____

2. Name; _____ Dose _____ Time _____

Dispensing and Storage Instructions: _____

Possible side effects: _____

3. Name; _____ Dose _____ Time _____

Dispensing and Storage Instructions: _____

Possible side effects: _____

Other Information:

I understand that it is my responsibility to give the medication directly to program staff, with full instructions, in individual dosage containers, already labeled envelopes, or in original prescriptions 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 Park District Staff if there are any changes in the dispensing of medication.

Signature of Parent

Date