CAROL STREAM Park District

Permission to Dispense Medication

ONE MEDICATION PER FORM

Medication distribution will be provided for participants who, for whatever reason, cannot properly take their prescribed medication independently during a Carol Stream Park District sponsored program. Parent or Guardian will provide the Carol Stream Park District staff with the child's medication in the original container whose prescription label must include the following: Patient's Name, Physician's Name, Pharmacy Name, Name of Medication and Complete Dosage Information. The proper dosage for the day should be sent in the original container each day. More than one dosage will not be accepted. If the original container is not available, parent should try to obtain a new one from their physician or pharmacy.

Child's Name _____

☐ **This medication is for a life threatening situation**

Name of Medication _____

Purpose of Medication _____

Dose _____ Time Of Day _____

Indicate how the medication should be stored: ☐ Refrigerated ☐ Room Temperature ☐ Other

Indicate how the medication should be administered:

☐ Whole ☐ Chewed

☐ With Food ☐ Without Food

☐ With Water ☐ Without Water

Possible Side Effects _____

I understand it is my responsibility to give any and all medications directly to the Carol Stream Park District staff in the original containers whose prescription labels must include the following: Participant's Name, Physician's Name, Pharmacy Name, Name of Medication and Complete Dosage Information

If after administering any medication there is an adverse reaction, I give my permission to the Carol Stream 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. In consideration of the Carol Stream Park District administering medication to my minor child, I do hereby fully and forever release and discharge the Carol Stream Park District and its officers, agents, servants and employees from any and all claims I may have as a result of the Carol Stream Park District staff assisting in the administering of medication to my minor child.

I give permission to the Carol Stream Park District staff to administer the above stated medication to my child.

Parent/Guardian Name *(Print)*	**Phone Number**
Parent/Guardian Signature	**Date** MM/DD/YY

PROGRAM SUPERVISOR USE ONLY

_____ STAFF INITIAL _____ DATE ☐ PARENT VERIFIED DATE