

Rolling Meadows Park District Medication Dispensing Information

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

BACKGROUND INFORMATION:

Participant's Name: _____ Age: _____

Complete Address: _____

Parent's/Guardian's Name(s) _____

Daytime Phone: _____ Other Phone: _____

Program Name: _____

Doctor's Name: _____ Phone: _____

MEDICATION INFORMATION:

1. Name: _____ Dose: _____ Time: _____

Dispensing & Storage Instructions: _____

Possible Side Effects: _____

2. Name: _____ Dose: _____ Time: _____

Dispensing & Storage Instructions: _____

Possible Side Effects: _____

3. Name: _____ Dose: _____ Time: _____

Dispensing & Storage Instructions: _____

Possible Side Effects: _____

ADDITIONAL INFORMATION: _____

WAIVER & REALEASE OF ALL CLAIMS

The Rolling Meadows Park District will not dispense medication to a minor child or other participant until this form has been fully completed by a parent or guardian. The Rolling Meadows Park District’s internal procedures on dispensing medication are available for review.

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 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 Rolling Meadows 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 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 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 Rolling Meadows Park District administering medication to my minor child, I do hereby fully release or discharge the Rolling Meadows 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.

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 Rolling Meadows Park District if any changes in the dispensing of medication change.

Signature of Parent/Guardian

Date