MEDICATION DISPENSING INFORMATION FORM
(This form must be completed for each program session or when medication changes)

PARTICIPANT INFORMATION:
Participant’s Name: ____________________ Age: _______ Program Name: __________________

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 Time to be administered: ______ am Time to be administered: ______ 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 Time to be administered: ______ am Time to be administered: ______ 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 __________________

The Buffalo Grove Park District will not dispense medication to a minor child or other participant until the Medication Dispensing Information Form have been fully completed by a parent or guardian. The agency’s internal procedures on dispensing medication are available for review.

I, (print name) _____________________________ the parent/guardian of said child give permission to the staff of the Buffalo Grove Park District to administer to my child medication as stated above.

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.

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

(______) __________________ (______) __________________
Parent or Guardian Home Phone Parent or Guardian Alternate Phone (Work or Cell)