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: _____ a.m.  Time to be administered: _____ a.m.  Time to be administered: _____ a.m.
_____ p.m.        _____ p.m.        _____ p.m.
_________________________________________________________________________________

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: _____ a.m.  Time to be administered: _____ a.m.  Time to be administered: _____ a.m.
_____ p.m.        _____ p.m.        _____ p.m.
_________________________________________________________________________________

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)