



BUFFALO GROVE PARK DISTRICT

# MEDICATION DISPENSING INFORMATION FORM

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

## PARTICIPANT INFORMATION:

Participant's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Camp/School Site 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 \_\_\_\_\_ pm      Time to be administered: \_\_\_\_\_ am \_\_\_\_\_ pm      Time to be administered: \_\_\_\_\_ am \_\_\_\_\_ 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 \_\_\_\_\_ pm      Time to be administered: \_\_\_\_\_ am \_\_\_\_\_ pm      Time to be administered: \_\_\_\_\_ am \_\_\_\_\_ 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 Primary Phone

( ) \_\_\_\_\_  
Parent or Guardian Alternate Phone

**Office Use Only:**  
Risk Management: \_\_\_\_\_ Date: \_\_\_\_\_