

Dispensing Medication Authorization

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

Program Name: _____ Date Completed: _____

PARTICIPANT INFORMATION

Participant's Name: _____ Age: _____

Address: _____ City/State/Zip: _____

Parent/Guardian Name: _____ Cell Phone: _____

MEDICATION INFORMATION

Medication Name: _____ Prescription #: _____

Dosage Instructions: _____

Frequency Medication Must Be Administered: _____

Time Medication Must Be Administered: _____

Possible Side Effects: _____

Dispensing and Storage Instructions: _____

Does the child have any limitations which will occur due to the listed medication? ☐ Yes ☐ No

Other Information: _____

I understand that it is my responsibility to give the medication directly to program manager with full instruction in individual dosage containers, clearly labeled envelopes, or in original prescription bottles.

I authorize Glencoe Park District to administer specific medication listed above.

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 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 agency if any changes in the dispensing of medication change.

Parent/Guardian Signature: _____ Date: _____

