

MEDICATION DISPENSING INFORMATION

THIS FORM MUST BE COMPLETED FOR EACH PROGRAM SEASON OR WHEN MEDICATION CHANGES.

BACKGROUND INFORMATION:

Participant's Name: _____ Age: _____
Address: _____
Parent/Guardian Name(s): _____
Daytime Phone: () _____ Home Phone: () _____
Doctor's Name: _____ Phone: () _____
Program Name: _____

MEDICATION INFORMATION:

Medication Name: _____ Dose: _____ Time: _____
Dispensing & Storage Instructions: _____
Possible Side Effects: _____

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Dispensing & Storage Instructions: _____
Possible Side Effects: _____

OTHER INFORMATION:

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, 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 occur.

X _____
Signature of Parent/Guardian

Date