



Palatine Park District

PERMISSION AND WAIVER TO DISPENSE MEDICATION

The Palatine Park District will not dispense medication to a minor child or other participant until the Permission and Waiver to Dispense Medication and Medication Dispensing Information Forms have been fully completed by a parent or guardian. The Park District's internal procedures on dispensing medication are available for review.

NAME OF PROGRAM: _____ **DATE:** _____

I, _____ the parent/guardian of _____
(Print Name) (Print Name)

give permission to the staff of the Palatine Park District to administer to my child:

(Name of Medication)

I understand it is my responsibility to give the medication directly to the program staff:

- RX medication in the original prescription container(s);
- Over-the-counter medication(s) in original, sealed container(s);

All medications must be clearly labeled with the following information:

PARTICIPANT'S NAME: _____

NAME OF MEDICINE AND COMPLETE DOSAGE INSTRUCTIONS: _____

I understand that in no instance will the recommended dosage of any medication be exceeded. If after administering medication there is an adverse reaction, I give my permission to the Palatine Park District to secure from any licensed hospital physician and/or medical personnel any treatment deemed necessary for immediate care. I agree to be responsible for payment of all medical services rendered.

WAIVER & RELEASE OF ALL CLAIMS

I recognize and acknowledge that there are certain risks in connection with administering medication to my minor child. Such risks include, but are not limited to, failing to properly administer the medication, failing to observe side effects, failing to assess and/or recognize an adverse reaction, failing to assess and/or recognize a medical emergency, and failing to recognize the need to summon emergency medical services.

In consideration of the Palatine Park District administering medication to my minor child, I do hereby fully release and forever discharge the Palatine Park District and its officers agents, volunteers and employees from any and all claims from injuries, damages or loss, regardless of severity, I or my minor child may have (or accrue to me or my minor child), arising out of, in connected with, incidental to, or in any way associated with the administering of medication. If submitting this form online or via fax, my on-line or facsimile signature shall substitute for and have the same legal effect as an original signature.

SIGNATURE OF PARENT OR GUARDIAN: _____

DATE: _____



Palatine Park District

MEDICATION DISPENSING INFORMATION

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

BACKGROUND INFORMATION

Participant's Name: _____ Age: _____

Address: _____ City/State/Zip: _____

Parent's/Guardian's Name(s) _____

Daytime Phone: _____ Other Phone: _____

Program Name: _____

Doctor's Name: _____ Phone: _____

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MEDICATION INFORMATION

1. Name: _____ Dose: _____ Time: _____

Symptoms / Reason for issuing medication: _____

Dispensing and Storage Instructions: _____

Possible Side Effects: _____

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2. Name: _____ Dose: _____ Time: _____

Symptoms / Reason for issuing medication: _____

Dispensing and Storage Instructions: _____

Possible Side Effects: _____

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Signature required on reverse side.

ACKNOWLEDGEMENT

I understand that it is my responsibility to give prescription medication in the original prescription bottle with label intact. Non-prescription medication shall be in the original unopened bottle which includes the person's name, medication, dosage, and time of day medication is to be given.

In all cases, medication dispensing can only be changed or modified by completing another Permission and Waiver to Dispense Medication Form and Medication Dispensing 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 understand that it is my responsibility to inform the Park District if any changes in the dispensing of medication occur and when to cease dispensing the medication.

If submitting this form online or via fax, my online or facsimile signature shall substitute for and have the same legal effect as an original signature.

Signature of Parent or Guardian: _____

Date: _____