Park District of La Grange
Medication Dispensing Information

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

BACKGROUND INFORMATION:

Participants Name:_____

Age:_____

Address:_____

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

Daytime Phone:_____ Other Phone:_____

Program Name:_____

Doctor's Name:_____ Phone:_____

MEDICATION INFORMATION:

1 . Name:_____ Dose:_____ Time:_____

Dispensing & Storage Instructions:_____

_____

Possible Side Effects:_____

_____

2 . Name:_____ Dose:_____ Time:_____

Dispensing & Storage Instructions:_____

_____

Possible Side Effects:_____

_____

3 . Name:_____ Dose:_____ Time:_____

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 change.

_____ _____

Parent/Guardian Signature **Date**