FRANKFORT SQUARE PARK DISTRICT
PERMISSION TO DISPENSE MEDICATION FORM

Child's Name:

Doctor's Name: | Office Phone:

Medication Name	Dose	Time of Day	Reason

How is the medication taken? (please check all that apply):

☐ whole ☐ chewed ☐ crushed ☐ with water ☐ without water ☐ mixed with food ☐ after eating

☐ other explain:_____

Dispensing and Storage Instructions:

Possible Side Effects:

Waiver & Release of All Claims

I give my permission to the staff of the Frankfort Square Park District to administer the medication listed above to my child.

I understand that it is my responsibility to give the medication directly to the program staff, in the original container(s), clearly labeled with the following information: pharmacy's name, doctor's name, patient's name, medication name, strength, and dosage instructions.

In all cases, the recommended dosage of any medication will not be exceeded. If after administering medication there is an adverse reaction, I give my permission to the Frankfort Square 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 any and all medical services rendered.

In consideration of the Frankfort Square Park District administering medication to my minor child, I do hereby fully and forever release and discharge the Frankfort Square Park District and its officers, agents, servants, and employees from any and all claims I may have as a result of the Frankfort Square Park District staff assisting in the administering of medication to my minor child.

I recognize and acknowledge that there are certain risks of physical injury in connection with the administering of mediation 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 Frankfort Square Park District administering medication to my minor child, I do hereby fully release or discharge the Frankfort Square Park District, and its officer, agents, volunteers, and employees from any and all claims from injuries, damages, and losses I or my minor child may have (or accrue to me or my minor child), and arising out of, connected with, incidental to, or in any way associated with the administering of medication.

In all cases, medication dispensing can only be changed or modified by completing another *Permission to Dispense Medication form* and *Waiver & Release of All Claims*.

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 mediation change.

Parent/Guardian Signature: | Date:

MEDICATION LOG
(To be filled out by staff only)

Child's Name:

A:	Medication Name:	Dose:	Time:
B:	Medication Name:	Dose:	Time:
C:	Medication Name:	Dose:	Time:

Med.	Date	Time	Int.	Med.	Date	Time	Int.	Med.	Date	Time	Int.