Warren Special Recreation Association

100 S. Greenleaf St., Gurnee IL 60031

Inspiring People With Disabilities Through Meaningful Recreation

MEDICATION DISPENSING INFORMATION

This form must be completed for each program session or when medication changes.
This form should also include general pain relievers and antacids.

BACKGROUND INFORMATION:

Participant's Name: ____ Age: _________

Address: ____

Parent's/Guardian's Name(s): ____

Daytime Phone: __________________________ Other Phone: ___________________________

Program Name: ____

Doctor's Name: ________________________________ Phone: _____________________________

MEDICATION INFORMATION:

1.) Medication Name: _______________________________ Dose: __________ Time: _________

Dispensing and Storage Instructions: ____

____

2.) Medication Name: _______________________________ Dose: __________ Time: _________

Dispensing and Storage Instructions: ____

____

3.) Medication Name: _______________________________ Dose: __________ Time: _________

Dispensing and Storage Instructions: ____

____

4.) Medication Name: _______________________________ Dose: __________ Time: _________

Dispensing and Storage Instructions: ____

____

4). Medication Name:________________________________Dose:______________Time:_____________

Dispensing and Storage Instructions:____

____

Possible Side Effects:____

OTHER INFORMATION:

____

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____

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____

____

I understand that it is my responsibility to give the medication directly to the program staff with full instructions in individual dosage containers 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.

______________________________ ______________________________

Signature of Parent or Guardian Date

WARREN SPECIAL RECREATION ASSOCIATION

Warren Special Recreation Association

100 S. Greenleaf St., Gurnee IL 60031

Inspiring People With Disabilities Through Meaningful Recreation

Brenda Zeck
Executive Director

Board of Directors

Nancy Carlson
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Suzanne Simpson
Vice President

Susie Kuruvilla
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Board Member

PERMISSION TO DISPENSE MEDICATION

Waiver and Release of All Claims

The Warren Special Recreation Association will not dispense medication to a minor child or other participant until the Permission and Waiver to Dispense Medication and Medication Information Form have been fully completed by a parent or guardian. The agency's internal procedures on dispensing medication are available for review.

NAME OF PROGRAM:______________________________DATE:___________

I, ________________________, the parent/guardian of ______________________, give permission to the staff of Warren Special Recreation Association to administer to my child ____

(Name of medications(s))

I understand that it is my responsibility to give the medication directly to the program staff in individual dosage containers, original prescription containers, or envelopes clearly labeled with the following information.

PARTICIPANT'S NAME:____

NAME OF MEDICATION AND COMPLETE DOSAGE INSTRUCTIONS:

____

____

In all cases their recommended dosage of any medication will not be exceeded. If after administering medication there is an adverse reaction, I give my permission to the Warren Special Recreation Association (WSRA) to secure from any licensed hospital physician and/or medical personnel any treatment necessary for immediate care. I agree to be responsible for payment of any and all medical services rendered.

I recognize and acknowledge that there are certain risks of physical injury in connection with the administering of medication to my minor child. In consideration of WSRA administering medication to my minor child, I do hereby fully release or discharge WSRA, and its officers, agents, volunteers and employees from any and all claims resulting from injured, damages and losses sustained by me or my minor child arising out of, connected with, incidental to or in any way associated with the administering of medication.

_________________________________ ___________________________

Signature of Parent or Guardian Date