



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

Program Name: _____

Participant's Name (print) _____ Age: _____

Parent/Guardian's Name (print): _____ Phone Number: _____

Address _____ City _____

State _____ Zip _____ Email _____

Doctor's Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone Number: _____

Medication Information

Name: _____ Dose: _____ Time: _____

Storage instructions and specific recommendations for administration:

Possible side effects and instructions:

Any severe adverse reactions that may occur to another child if they come in contact with/receive a dose of medication?

Name: _____ Dose: _____ Time: _____

Storage instructions and specific recommendations for administration:

Possible side effects and instructions:

Any severe adverse reactions that may occur to another child if they come in contact with/receive a dose of medication?

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

Date _____