# Medication Dispensing Information

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

**BACKGROUND INFORMATION:**

Participant's Name:_____ Age:_____

Address:_____

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:_____

   Dispensing & Storage Instructions:_____

   _____

   Possible Side Effects:_____

   _____

   (*Answer the following question only if there will be use of an epinephrine auto-injector or inhaler)*
   List any severe adverse reactions that may occur to another child, for whom the epinephrine auto-injector or inhaler is not prescribed, should the other child receive a dose of the medication:
   _____

   _____

2. Name:_____Dose:_____Time:_____

   Dispensing & Storage Instructions:_____

_____

Possible Side Effects:_____

_____

(*Answer the following question only if there will be use of an epinephrine auto-injector or inhaler):*

List any severe adverse reactions that may occur to another child, for whom the epinephrine auto-injector or inhaler is not prescribed, should the other child receive a dose of the medication:

_____

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_____

3. Name:_____Dose:_____Time:_____

Dispensing & Storage Instructions:_____

_____

Possible Side Effects:_____

_____

(*Answer the following question only if there will be use of an epinephrine auto-injector or inhaler):*

List any severe adverse reactions that may occur to another child, for whom the epinephrine auto-injector or inhaler is not prescribed, should the other child receive a dose of the 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.**

_____ _____

**Signature of Parent or Guardian** **Date**

**DES PLAINES PARK DISTRICT**

# Permission To Dispense Medication
## *Waiver and Release of All Claims*

The Des Plaines Park District 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. Additionally, if applicable, the Waiver & Release of all Claims for use of Inhaler or Auto-Injector. The agency's internal procedures on dispensing medication are available for review.

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**NAME OF PROGRAM:**_____DATE:_____

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

give permission to the staff of the Des Plaines Park District

**to administer to my child** _____.
(Name of Medication)

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**I understand 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 MEDICINE AND COMPLETE 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 Des Plaines 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.**

## WAIVER & RELEASE OF ALL CLIAMS

**I recognize and acknowledge that there are certain risks of physical injury in connection with the administering of 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 Des Plaines Park District administering medication to my minor child, I do hereby fully release or discharge the Des Plaines 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.**

_____ _____

**Signature of Parent or Guardian** **Date**

# Des Plaines Park District
# WAIVER & RELEASE OF ALL CLAIMS FOR USE OF INHALER OR AUTO-INJECTOR

***(Only to be completed if applicable, and there will be use of an Inhaler or Auto-Injector)***

**WAIVER AND RELEASE OF ALL CLAIMS AND INDEMNIFICATION**

Please read this form carefully and be aware that pursuant to the Illinois Asthma Inhalers at Recreational Camps Act, 410 ILCS 607/1 *et seq.,* you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages or loss which you or your minor child/ward might sustain in connection with the possession, self-administration, or use of medication, including, but not limited to the use of an epinephrine auto-injector or inhaler at the camp or at any camp-sponsored activity, event, or program; except for claims arising out of the willful and wanton conduct of the Des Plaines Park District.

As parent/guardian of the below identified participant, I verify and attest that my child/ward has the knowledge and skills to safely possess, self-administer, and use an epinephrine auto-injector or inhaler in a camp setting. I also recognize and acknowledge that there are certain risks of physical injury to participants' possession, self-administration, or use of medication, and I voluntarily agree to assume the full risk of any and all injuries, damages or loss, regardless of severity, that my minor child/ward or I may sustain as a result of said possession, self-administration, or use of medication. 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.

I further agree to waive and relinquish all claims I or my minor child/ward may have (or accrue to me or my child/ward) as a result of or arising out of the possession, self-administration, or use of medication against the Des Plaines Park District, including its officials, agents, volunteers and employees; except for claims arising out of the willful and wanton conduct of the Des Plaines Park District.

I further agree to protect, indemnify, save, defend and hold harmless the Des Plaines Park District from and against any and all liabilities, obligations, claims, damages, penalties, causes of action, costs and expenses (including reasonable attorney fees) for which the Des Plaines Park District may become obligated by reason of the possession, self-administration, or use of medication; except to the extent caused by the willful and wanton conduct of the Des Plaines Park District.

**I have read and fully understand the above waiver and release of all claims and indemnification. If registering on-line or via fax, my on-line or facsimile signature shall substitute for and have the same legal effect as an original form signature.**

PLEASE PRINT

Participant's Name

_____

Parent/Guardian's Signature

_____

Date_____

**PARTICIPATION WILL BE DENIED**
**If the signature of parent/guardian and date are not on this waiver.**