WAUCONDA PARK DISTRICT
PERMISSION TO DISPENSE MEDICATION
(Fill out only if needed)

Participant's Name: Age:

Name of Medication	Dose	Time of Day	Reason

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

☐ Whole ☐ Chewed ☐ Mixed with Water

☐ With Water ☐ Without Water ☐ After Eating

Administers to:

☐ self ☐ need staff's assistance

Any adverse reactions: _____

Special Instructions: _____

I, _____, the parent/legal guardian of _____ give my permission to the Staff of the Wauconda Park District to administer the above medication to my child/teen.

I understand it is my responsibility to give the medication directly to the program staff in the original dosage containers clearly labeled with the following information: Pharmacy name, Doctor's name, patient's name, type of medication, strength and dose 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 Wauconda 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 Wauconda Park District administering medication to my minor child, I do hereby fully and forever release and discharge the Wauconda Park District and its officers, agents, servants, and employees from any and all claims I may have as a result of the Wauconda Park District Staff assisting in the administering of medication to my minor child.

Parent/Guardian Signature: _____ **Date:** _____