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:_____Cell/Pager #:_____

Doctor's Name:_____Phone:_____

MEDICATION INFORMATION

Name:_____Dose:_____Time:_____

Dispensing & Storage Instructions:_____

_____

Possible Side Effects:_____

_____

Name:_____Dose:_____Time:_____

Dispensing & Storage Instruction:_____

_____

Possible Side Effects:_____

_____

Name:_____Dose:_____Time:_____

Dispensing & Storage Instructions:_____

_____

Possible Side Effects:_____

_____

OTHER INFORMATION:

_____

_____

_____

_____

I understand that it is my responsibility to give the medication directly to the Teacher 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**