Permission to Dispense Medication

Attention: Please return to park district if your child needs to take medication.

Child's Name: ______________________________

Doctor's Name: ______________________________ **Office Phone:** ______________________________

Medication Name	Dose	Time of Day	Reason

How is the medication taken:

☐ **Whole** ☐ **Chewed** ☐ **Crushed** ☐ **With Water** ☐ **Without Water** ☐ **Mixed**

☐ **After Eating** ☐ **Other/Explain:** ______________________________

Special Insructions: ______________________________

Any adverse reactions to medication: ______________________________

Please Note: All medications must be in their original container and clearly marked with the child's first and last name, medication name, doctor's name, dosage, and other specific instructions. All medications will be kept with your child's counselor. Our staff is not authorized to directly administer any medications. If needed, a staff member will verbally assist your child in taking their medication.

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Parent Signature **Date**