



Permission to Dispense Medication

Attention: Please return this form to the 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 Instructions: _____

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.

Parent Signature

Date