SRACLC Medication Dispensing Information and Waiver

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

Season/Year: _____

Participant Information

Name: _____ Age: _____

Address: _____

Parent's/Guardian's Name(s): _____

Daytime Phone: _____ Other Phone: _____

Doctor's Name: _____ Doctor's Phone: _____

Medication Information

1. Name: _____ Dose: _____ Time: _____

   Dispensing & Storage Instructions: _____

   Possible Side Effects: _____

Staff Use Only: Please initial with date and time for each medication (#1) that is dispensed.			
Initial	Date	Initial	Date
	Time		Time

2. Name: _____ Dose: _____ Time: _____

   Dispensing & Storage Instructions: _____

   Possible Side Effects: _____

Staff Use Only: Please initial with date and time for each medication (#2) that is dispensed.			
Initial	Date	Initial	Date
	Time		Time

I understand that it is my responsibility to give medication directly to the SRACLC Office in the original prescription bottle with the doctor's instructions included.

In all cases, medication dispensing can only be changed or modified by completing another Medication Dispensing Information Form.

I hereby acknowledge that the about information provided for the dispensing of the medication for my child, ward, or family member is accurate. I also understand that it is my responsibility to inform the agency of any changes in the dispensing of medication in writing.

Signature of Parent or Guardian: _____ **Date:** _____

*Form will be kept with program staff.