**Permission To Dispense Prescribed Medication**

***(Confidential)***

CHURCH, ADDRESS

**Parent or Legal Guardian Authorization for**

**Dispensation of Prescribed Medication**

*Waiver and Release of All Claims*

CHURCH will only dispense prescribed medication to a minor child when the Permission To Dispense Prescribed Medication Form has been fully completed by a parent/legal guardian. CHURCH’s internal procedures on dispensing medication are available for review.

**PLEASE NOTE THAT THIS FORM IS VALID FOR THE ENTIRE PROGRAM YEAR – AUGUST THROUGH JULY.**

**IT IS THE PARENT’S OR LEGAL GUARDIAN’S RESPONSIBILITY TO NOTIFY THE STAFF OF ANY CHANGES THAT NEED TO BE MADE DURING THE PROGRAM YEAR IN WRITING.**

**PROGRAM YEAR:**

**To be completed by parent/guardian:**

I request and give permission for (name of child) to receive the prescribed medication(s)/ treatment listed on the reverse side of this form during CHURCH sponsored events according to CHURCH policy and for the physician(‘s)/staff and church leadership/staff to share information needed to assist my child with medication needs.

 I understand it is my responsibility to give the medication directly to the program staff in original prescription containers clearly labeled with my child’s name and the dispensing information as indicated on the reverse side of this form.

 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 CHURCH to secure from any licensed hospital physician and/or medical personnel any and all medical services necessary.

 I recognize and acknowledge that there are certain risks of physical injury in connection with the administering of medication to my minor child. In consideration of CHURCH administering medication to my minor child, I do hereby fully release or discharge CHURCH, and its officers, agents, volunteers, and employees from any and all claims from injuries, damages and losses I or my minor child may have, arising out of, connected with, incidental to, or in any way associated with the administering of medication. I further agree to indemnify, hold harmless, and defend CHURCH, and its officers, agents, volunteers, and employees from any and all claims resulting from injuries, damages and losses sustained by me or my minor child arising out of, connected with, incidental to, or in any way associated with the administering of medication.

 In all cases, dispensing of prescribed medication can only be changed or modified by completing another Permission to Dispense Prescribed Medication Form.

Parent signature Date Parent phone number

**MEDICATION INFORMATION FOR PRESCRIBED MEDICATION**

THIS FORM MUST BE COMPLETED FOR EACH PROGRAM YEAR OR WHEN

MEDICATION NEEDS CHANGE.

**BACKGROUND INFORMATION** (Please print)**:**

Minor Child’s Name: Age:

Address

Parent/Guardian Name(s):

Daytime Phone: Home Phone:

Doctor’s Name: Phone:

**MEDICATION INFORMATION:**

**Medication Name**: Dose: Time:

Dispensing & Storage Instructions:

Possible Side Effects:

**Medication Name**: Dose: Time:

Dispensing & Storage Instructions:

Possible Side Effects:

**Medication Name**: Dose: Time:

Dispensing & Storage Instructions:

Possible Side Effects:

**OTHER INFORMATION:**

*I understand it is my responsibility to give the medication directly to the program staff in original prescription containers clearly labeled with my child’s name and the dispensing information as indicated above*.

*In all cases, medication dispensing can only be changed or modified by completing another Permission To Dispense Prescribed Medication Form.*

*I hereby acknowledge that the above information provided for the dispensing of prescribed medication to my minor child is accurate.*

X

Signature of Parent/Guardian Date

Processed by: Date: