Parkland College Community Education will not dispense medication to a minor child or other participants until the *Permission to Dispense Medication Waiver and Release of All Claims* form has been completed by a parent / guardian. Please return completed forms to Terry Thies at tthies@parkland.edu.

PERMISSION TO DISPENSE MEDICATION
Waiver and Release of All Claims

I, (please print your name) ____, the Parent / Guardian of (please print name of participant) ____, give permission to Community Education staff to administer to my child the medication(s) listed below. I understand that it is my responsibility to give the medication directly to Community Education staff with full instructions in original prescription bottles. In all cases, medication dispensing can only be changed or modified by completing another Permission to Dispense Medication / Waiver and Release of All Claims form. I hereby acknowledge that the above information provided for the dispensing of medication for my minor child, ward, or other family member is accurate. I also understand that it is my responsibility to inform Community Education in writing of any changes in the dispensing of medication.

Name of Medication: ____
Reason medication is needed during camp hours: ____
Dispensing and Storage Instructions: ____
Complete Dosage Instructions: ____
Date to start medication: ____
Time medication should be dispensed: ____
Possible Side Effects: ____
Plan of Management of Side Effects: ____
Any Known Allergies to Medications: ____
Reactions to Medication: ____

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Possible Side Effects: ____
Plan of Management of Side Effects: ____
Any Known Allergies to Medications: ____
Reactions to Medication: ____

I hereby give permission for the facility/school to administer medicine as prescribed above. **I also give permission for the staff to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

Parent or Guardian Name (Print)

Parent or Guardian Signature

Address

Home Phone Number | Work Phone Number | Cell Phone Number

Prescriber Information

Prescribing Health Professional's Name: ______________________________

Phone Number: ______________________