



LAKE COUNTY FOREST PRESERVES  
www.LCFPD.org

Preservation, Restoration, Education and Recreation

## Medication Dispensing Information, Permission, and Waiver

**Only fill out this form if you expect camp staff to dispense medication to your child, when medication changes, or if your child will carry an asthma inhaler and/or EpiPen.** The Lake County Forest Preserves will not dispense medication to a minor child or other participant until the Medication Dispensing Information, Permission, and Waiver form has been fully completed by a parent/guardian.

### Background Information

Camper's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Parent/Guardian Phone: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Camp Program and Session Date(s): _____	Camp Location/Preserve: _____
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### Medication Information

1. Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Time dispensed: \_\_\_\_\_

Dispensing Instructions: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

Complete Dosage Instructions \_\_\_\_\_

2. Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Time dispensed: \_\_\_\_\_

Dispensing Instructions: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

Complete Dosage Instructions \_\_\_\_\_

My child has permission to carry and knows how to properly use their own \_\_\_\_\_ and has been instructed not to show or share it with others. \_\_\_\_\_ Initial

Inhaler

EpiPen

I understand that it is my responsibility to give the medication (pills or other items that are not asthma inhalers or EpiPens) directly to program staff with full instructions in individual dosage containers, clearly labeled envelopes, or in original prescription bottles with the following information:

- Name of camper
- Medication
- Dosage
- Time of day to be given
- Prescribing Doctor
- Doctor's phone number

In all cases, medication dispensing can only be changed or modified by completing a new Medication Dispensing Information, Permission, and Waiver form. I hereby acknowledge that the above information provided for the dispensing of medication for my minor child, guardian, ward, or other family member is accurate. I also understand that it is my responsibility to inform the agency if any changes in the dispensing of medication change.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

## Permission to Dispense Medication

I \_\_\_\_\_ the parent/guardian of \_\_\_\_\_  
(Print Your Name) (Print Child's Name)

give permission to the staff of the Lake County Forest Preserves to administer to my child the following:

\_\_\_\_\_  
Medication(s)

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 the Lake County Forest Preserves to secure from any licensed hospital physician and/or medical personnel any treatment deemed necessary for immediate care. I agree to be responsible for payment of any and all medical services rendered.

## Waiver and Release of All Claims

I recognize and acknowledge that there are certain risks of physical injury in connection with the administering of medication to my minor child. Such risks include, but are not limited to, failing to properly administer the medication, failing to observe side effects, failing to assess and/or recognize an adverse reaction, failing to assess and/or recognize a medical emergency, and failing to recognize the need to summon emergency medical services.

In consideration of the Lake County Forest Preserve District administering medication to my minor child, I do hereby fully release or discharge the Lake County Forest Preserve District, and its officers, agents, volunteers and employees from any and all claims from injuries, damages and losses I or my minor child may have (or accrue to me or my minor child), and arising out of, connected with, incidental to, or in any way associated with the administering of medication.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date