

Grayslake Community Park District

240 Commerce Drive

Grayslake, IL 60030

(847) 223-7529

www.glpd.com



**Permission to Dispense Medication
2020-2021 School Year**

Participant Name	Gender	Birthdate

Address:		
City:	State:	Zip Code:

Name of Medication	Dose	Time of Day	Reason

How is the medication taken (Please check all that apply):

- Swallow Whole
- Chewed
- With Food
- With Water
- Without Water
- After Eating

Other: _____

Any adverse reactions?

Special Instructions: _____

I, _____, the parent/guardian of _____ give permission to the staff of the Grayslake Park District to administer the above medication to my child.

I understand it is my responsibility to give the medication directly to the program staff in the original dosage containers clearly labeled with the following information: Pharmacy's name, Doctor's name, Patient's name, Type of medications, Strength, and Dosage instructions.

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 Grayslake Park District 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.

In consideration of the Grayslake Park District administering medication to my minor child, I do hereby fully and forever release and discharge the Grayslake Park District and its officers, agents, servants and employees from any and all claims I may have as a result of the Grayslake Park District Staff assisting in the administering of medication to my minor child.

Parent/Guardian Signature _____

Date _____