



Medication Dispensing Information Form

Participant's Name: _____ Age: _____

Address: _____

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

Daytime Phone: _____ Other Phone: _____

Program Name: _____

Doctor: _____ Phone: _____

Insurance Company: _____ Policy #: _____

Does participant have allergies? YES NO

If yes, please list _____

Is participant taking medication? YES NO

If yes, please fill complete the following information:

1. Name of Medication: _____ Dose: _____
Time to Administer: _____

Dispensing/Storage Instructions: _____

Possible Side Effects: _____

2. Name of Medication: _____ Dose: _____
Time to Administer: _____

Dispensing/Storage Instructions: _____

Possible Side Effects: _____

Parent/Guardian Signature

Date

Authorization to Dispense Medication

The undersigned acknowledges that any and all medications are given to City of Scottsdale staff and/or the Nurse/EMT in their original container and that instructions on the pharmaceutical container are accurate. Parent/Guardian understands child's medications will be stored in the medical lock box on site. Furthermore, the undersigned agrees to allow the City of Scottsdale staff and or the Nurse/EMT to store and present medication to the participant or legal charge and waive any claims against the City of Scottsdale and/or its staff.

Parent/Guardian Signature

Date

Participant Name

Date