



Kid's Connection Before and After School Medication Dispensing & Authorization Form

City of Greenfield Parks and Recreation Department - 7325 W Forest Home Ave, Greenfield WI 53220

Phone: 414-329-5370 - Fax: 414-543-2369

Name of Child to Receive Medicine _____ Age _____ School _____

Parent/Guardian Name(s) _____

Primary Phone _____ Secondary Phone _____

To be completed by a Licensed Prescriber

Name of Medication: _____ Reason for Medication: _____

Dosage: _____ Time: _____ Frequency: _____

Dispensing & Storage Instructions: _____

For PRN Orders— Specific symptoms or conditions under which medication is to be given: _____

Possible Side Effects: _____

Actions to take if observed: _____

If there are additional details/notes that staff should know about this medication, please attach information to this sheet.

For Insulin, PRN Asthma Inhalers or Epi-Pens ONLY:

____ Yes ____ No This child has received adequate instruction about how and when to administer this medication and in my professional opinion is capable and responsible to carry and self-administer it. If no is selected, Kids Connection Staff will carry and help administer this medication.

Date of expiration _____ Phone _____ Fax _____

Licensed Prescriber's Name/Address (please print) _____

Licensed Prescriber's Signature _____ Date _____

Parent/Guardian Authorization (please initial below)

_____ I agree to deliver medication to Kids Connection staff in a pharmacy-labeled container.

_____ I agree to submit a new medication dispensing & authorization form if this prescription changes in anyway.

_____ I agree to maintain a sufficient supply of medication to Kids Connection and to pick up any unused medication.

I understand it is my responsibility to give the medication directly to the Kids Connection Greenfield Park and Recreation Staff in its original prescription container or envelope clearly labeled with your child's full name and full dosage instructions. I understand medication can only be administered in the amount according to the label directions. In all cases the recommended dosage of any medication will not be exceeded. If after administering medication there is an adverse reaction, I grant Kids Connection Greenfield Parks and Recreation staff 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.

I recognize and acknowledge that there are certain risks of physical injury in connection with administering of medication to my minor child, I do hereby fully release or discharge the Kids Connection Greenfield Parks and Recreation staff from any and all claims from injuries, damages and losses I or my minor child may have arising out of, connection with, incidental to or in any way associated with the administering of the specified medication.

I hereby acknowledge that the above information provided for dispensing medication for my minor child, is accurate. I also understand that it is my responsibility to inform staff of any changes in the dispensing of medication. By signing below, I give Kids Connection Greenfield Parks and Recreation staff permission to dispense medication to the child listed above.

Signature of Parent/Guardian: _____ Date: _____

Print Name of Parent/Guardian: _____