

**PERMISSION TO DISPENSE  
MEDICATION**

**PEACEBUILDERS INITIATIVE**

*This form must be completed by the child's parent or legal guardian for each program session or when medication changes.*

PLEASE ATTACH ANY PHYSICIAN NOTES TO THIS FORM.

**BACKGROUND INFORMATION:**

Participant's Name: \_\_\_\_\_ Age \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Parent's/Guardian's Name \_\_\_\_\_

Daytime Phone: ( ) \_\_\_\_\_ Other Phone: ( ) \_\_\_\_\_

Program Name: \_\_\_\_\_

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

Date of Contact with Doctor: \_\_\_\_\_

Doctor's Diagnosis: \_\_\_\_\_

**MEDICATION INFORMATION:**

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Time: \_\_\_\_\_

Date and Serial # of Medication: \_\_\_\_\_

Dates medication will be taken: \_\_\_\_\_

Dispensing & Storage Instructions: \_\_\_\_\_

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

Time Medication Is Taken At Home: \_\_\_\_\_

OTHER INFORMATION \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PERMISSION TO DISPENSE MEDICATION**

I understand that it is my responsibility to give the medication directly to program staff with full written instructions in original prescription bottles/containers.

In all cases, medication dispensing can only be changed or modified by completing another Permission and Waiver to Dispense Medication Form and Medication Information Form.

I hereby acknowledge that the above information provided for the dispensing of medication for my minor child, guardians, 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