GILBERT
ARIZONA

Emergency Medication Dispensing Information

Participant: _____ Age: _____

Parent/Guardian: _____

Contact Phone Number: _____

Description of Allergy or Medical Condition: _____

_____

Symptoms of Allergic Reaction or Medical Need:

_____

_____

Medication Information

Name of Medication: _____

When to Dispense: _____

_____

Dosage: _____

Specific Directions for Dispensing Medication: _____

_____

Possible Side Effects: _____

_____

Prescribing Physician: _____

Physician Contact Number: _____

In the event that staff members witness a life threatening injury or illness, staff will immediately call 9-1-1 regardless of whether we have medication on hand and attempt to make contact with the Parent/Guardian listed above.

The undersigned acknowledges that any and all medications are given to the Town of Gilbert staff in their original container and that instructions on the pharmaceutical container are accurate. Parent/guardian understands child's medications will be stored in a locked cabinet onsite. Furthermore, the undersigned agrees to allow the Town of Gilbert staff to store and present medication to the participant and waive any claims against the Town of Gilbert and/or its staff.

Parent Signature: _____ Date: _____

SUBMIT