WAUKEGAN PARK DISTRICT
MEDICAL INFORMATION FORM

Program:_____

General Information

Participant's Name: _____ Age: _____

Address: _____

Parent's/Guardian's Name: _____

Daytime Phone: _____ Other Phone: _____

Doctors Name: _____

Doctor's Phone Number: _____
(other numbers on the Emergency Contact form can be referenced)

In order for your child to have the best possible program experience, it is helpful for us to know if your child has ADD, ADHD, BD, learning disability, asthma, seizures, food allergies or anything else, which might affect his/her experience. Please disclose this type of information at your discretion.

_____

_____

_____

_____

Medication Information

Information on medications to be administered to the participant during program hours is required. In case of an emergency, it is also helpful to list any medication the participant receives on a regular basis but it is not mandatory that you share this information.

1. Name of Medication: _____ Dispensed by: ___staff ___guardian

Reason for medication: _____

_____

Possible side effect: _____

_____

2. Name of Medication: _____ Dispensed by: ___staff ___guardian

Reason for medication: _____ _____

_____

Possible side effect: _____

_____

(Continued on Back)

3. Name of Medication: _____ Dispensed by: ___staff ___guardian

Reason for medication: _____ _____

_____

Possible side effect:_____

_____

If a medication needs to be administered by Waukegan Park District staff, a 'Permission to Dispense Medication' form must be completed for each medication needing to be dispensed. In all cases, medication dispensing can only be administered, changed or modified by completing a 'Permission to Dispense Medication' form.

Other Information _____

_____

_____

Acknowledgement
I hereby acknowledge that the above information is accurate and I understand that it is my responsibility to inform the Waukegan Park District of any changes in the above information.

_____ _____
Signature of Parent or Guardian Date