Date: ___/____/____
Month Day Year

NISRA
Northern Illinois
Special Recreation Association

MEDICATION PERMISSION FORM

(This form must be completed annually or when medication changes)

*Participant's Name:*_____ *Age:* ___

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

Daytime Phone: _____*Other Phone:* _____

Doctor's Name: _____ *Phone:* _____

Office Use Only

Medication Name	*Dosage*	*Time (s)*	*Dispensing & Storing Instructions*	*Possible side effects*	*Date Given*	*Staff Initials*
1.						
2.						
3.						
4.						
5.						

Please Note: NISRA does not administer rectal Diastat

Northern Illinois Special Recreation Association
Medication Dispensing Waiver

I recognize and acknowledge that there are certain risks of physical injury in connection with administering of medication to my minor child or participant. In consideration of the Northern Illinois Special Recreation Association administering medication to my minor child or participant, I do hereby fully release or discharge NISRA, and its officers, agents, volunteers and employees from any and all claims from injuries, damages, and losses I or my minor child or participant may have, arising out of, connected with, incidental to, or in any way associated with the administering of medication. I further agree to indemnify, hold harmless and defend NISRA and its officers, agents, volunteers and employees from any and all claims resulting from injuries, damages and losses sustained by me or my minor child or participant and arising out of, connected with, incidental to or in any way associated with the administering of medication.

Parent/Guardian Signature _____Date _____