Heart of Illinois Special Recreation Association
8727 North Pioneer Road, Peoria, IL 61615
P: 309-691-1929, F: 309-691-4383
hisra@peoriaparks.org

Form #4: HISRA Medication Dispensing Information

This form must be completed for each medication to be administered and must be completed each calendar year and/or when the medication(s) changes. Please note that HISRA will not dispense medication to any participant until this form is completed in full by a parent or guardian.

Participant's Name: _____ DOB: _____

Name of Medication	
Dosage (mg)	
Time to be Administered (please indicate AM or PM)	
Storage Instructions	
Administering Instructions	
Possible Side Effects	

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Dosage (mg)	
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Possible Side Effects	

See reverse side for additional medication information and to sign required waiver

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The following are medications and treatments HISRA staff members are unable to dispense and provide to participants during programming. Please check any of the below treatments that apply to the participant and the HISRA office will contact you with more information:

- ☐ IV Medications
- ☐ Diazepam Rectal Gel Delivery
- ☐ Vagal Nerve Stimulator
- ☐ Tracheotomy Management
- ☐ Suction Device Management
- ☐ Nebulizer Therapy
- ☐ Insulin Pump Management
- ☐ Syringe Injections (insulin, etc.)

I, _____, (PARENT AND/OR GUARDIAN OF ABOVE NAMED PARTICIPANT) GIVE PERMISSION TO THE HISRA STAFF TO ADMINISTER THE ABOVE LISTED MEDICATION(S) AS PRESCRIBED. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO GIVE THE MEDICATION(S) DIRECTLY TO THE HISRA STAFF IN THE ORIGINAL PRESCRIPTION CONTAINER. IN ALL CASES, THE RECOMMENDED DOSAGE OF ANY MEDICATION(S) WILL NOT BE EXCEEDED. IF AFTER ADMINISTERING MEDICATION(S) THERE IS AN ADVERSE REACTION, I GIVE MY PERMISSION TO THE HISRA STAFF TO SECURE ANY TREATMENT, DEEMED NECESSARY FOR IMMEDICATE CARE, FROM ANY LICENSED HOSPITAL PHYSICIAN AND/OR MEDICAL PERSONNEL. 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 THE ADMINISTERING OF MEDICATION(S) TO THE PARTICIPANT. SUCH RISKS INCLUDE, BUT ARE NOT LIMITED TO, FAILING TO PROPERLY ADMINISTER THE MEDICATION, FAILING TO OBSERVE SIDE EFFECTS, FAILING TO ASSESS AND/OR RECOGNIZE A MEDICAL EMERGENCY AND FAILING TO RECOGNIZE THE NEED TO SUMMON EMERGENCY MEDICAL SERVICES. IN CONSIDERATION OF THE HISRA STAFF ADMINISTERING MEDICATION(S) TO THE PARTICIPANT, I DO HEREBY FULLY RELEASE OR DISCHARGE HISRA AND IT'S OFFICERS, AGENTS, VOLUNTEERS AND EMPLOYEES FROM ANY AND ALL CLAIMS FROM INJURIES, DAMAGES, AND LOSSES I OR THE PARTICIPANT HAVE (OR ACCRUE TO ME OR THE PARTICIPANT), AND ARISING OUT OF, CONNECTED WITH, INCIDENTAL TO, OR IN ANY WAY ASSOCIATED WITH THE ADMINISTERING OF MEDICATION(S).

_____ _____

Signature Of Parent Or Guardian Date