



## Prescription Medication Dispensing Agreement

**THIS FORM MUST BE COMPLETED BEFORE MEDICATION CAN BE GIVEN**

(This section to be completed by a licensed physician)

\_\_\_\_\_  
Child's Last Name                                      First Name                                      Gender                                      DOB

\_\_\_\_\_  
Purpose of Medication/Diagnosis                                      Name of Medication(s)

\_\_\_\_\_  
Date of Prescription                                      Length of Time Medication Will Be Necessary

\_\_\_\_\_  
Dosage Prescribed                                      Time Scheduled for Dose                                      Form (tablet, liquid, etc.)

The child for whom this medication is prescribed is under my care.

\_\_\_\_\_  
Printed Name of Licensed Physician                                      Signature of Licensed Physician

\_\_\_\_\_  
Address                                      Telephone Number                                      Date

(This section to be completed by parent or legal guardian)

When prescription medication is to be dispensed, I understand that it is my sole responsibility to give medication for my minor child directly to authorized Team Prime Time staff with full instructions in original prescription bottles only. I also understand that it is my sole responsibility to inform Team Prime Time of any changes or modifications in the dispensing of medication. In all cases, I recognize that medication dispensing can only be changed or modified by completing another Prescription Medication Dispensing Agreement.

I further recognize and acknowledge that there are certain risks of physical injury in connection with the administering of medications to my minor child. In consideration of Team Prime Time administering medications to my minor child, I do hereby fully release and discharge Team Prime Time and its owners, officers, agents and employees, and hold them harmless from any and all claims (and all costs and expenses arising from such claims) from injury, damage and loss that I, or my minor child, or any other person may incur or suffer in any way associated with the administering of medication to my minor child. If, after administering medication, my minor child experiences an adverse reaction, I do hereby give permission to Team Prime Time to secure from any licensed hospital or medical personnel any treatment deemed necessary for immediate care. I hereby agree to be responsible for payment of any and all medical services rendered.

\_\_\_\_\_  
Name of Parent or Guardian (please print)                                      Signature of Parent or Guardian                                      Date

\_\_\_\_\_  
Home Phone                                      Emergency Phone