Non-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